Local Evaluation of Morecambe Bay PACS Vanguard

Stage 2 Early Findings Report

May 2018

Executive Summary

Introduction

- The Better Care Together (BCT) programme in Morecambe Bay is one of 50 vanguard sites developing a new model of care in England. It was allocated £4.59 million in 2015 to deliver a Primary and Acute System (PACS) new model of care, which is being used to bring together health and care providers to improve health and wellbeing. A key part of its work has been the creation of 12 integrated care communities (ICCs) across Morecambe Bay to bring together local health and care organisations.

- Health and Social Care Evaluations (HASCE) at the University of Cumbria were commissioned to conduct the local evaluation of the BCT vanguard. The local evaluation is now in its second year; in its first year, the emerging changes and their associated outcomes across the vanguard activities was explored through qualitative research. The second year of the evaluation aims to develop a more in-depth and nuanced analysis of what is working for who and why by focusing on a new model of respiratory care developed by the Morecambe Bay Respiratory Network (MBRN). The evaluation has adopted a realist methodology to provide this depth of understanding.

- The qualitative data collection activities are ongoing and to date 17 interviews with staff involved in the implementation and delivery of the new respiratory care model have been conducted. The emerging findings presented in this interim report are based on this interview data.

A New Model of Respiratory Care

- The MBRN's model of respiratory care aims to deliver high standards in the management of respiratory disease across Morecambe Bay. Activity and costs from secondary care could be released to help develop the new model. Central to this model is respiratory specialists coming out of hospitals to work with primary and community care staff. New multi-disciplinary teams (MDTs) are a key part of this new way of working; it was expected that the MDTs would enable patient cases to be reviewed by secondary care staff alongside GPs, practice nurses, physiotherapists and other staff instead of being referred to an outpatients clinic. As the model develops, the MDTs are to be incorporated into a community clinic that will allow more complex patients to be reviewed and access different services.

- Newly established ICC respiratory teams headed by a lead GP are to work with a secondary care link staff. To develop and upskill these ICC teams, lead GPs are to be given access to consultants and other respiratory specialists, secondary care investigations and attend monthly MDTs to discuss more complex cases.

- The implementation of the new model is planned in three activity bundles; in the first, a GP lead and wider ICC respiratory team are to be established in five ICCs and MDTs set up in the two localities in which these ICCs are based; and the second bundle would see the model being rolled out in the remaining ICCs in Morecambe Bay and community respiratory services expanded. It was expected that this expansion would reduce the number of non-elective attendances and facilitate earlier discharge. Reflecting this, in the third activity bundle, specialist respiratory and acute bed capacity was to be reduced. The BCT's Delivery Group approved the roll out of the bundle 1 activities in August 2017 and the implementation of the model began in October 2017.

Interim Findings

- Year 2 evaluation data collection so far suggest that a range of factors are relevant to the context in which the new model of respiratory care is being delivered. These include disease prevalence (COPD and asthma prevalence is higher in Morecambe Bay than nationally) and the capacity of secondary, primary and community care services to respond to demand. The lack of capacity to meet demand was thought to affect care quality and inefficiencies or variations in care quality were commonly cited. It was thought that practice nurses were providing much of patients' respiratory care, which had led to the erosion of respiratory knowledge amongst GPs. Interviewees questioned whether the right patients were being referred to outpatient clinics and felt that more guidance on referral pathways was needed.

- Like all BCT vanguard activities, the new model of care was being implemented during a period of organisational change. The new Morecambe Bay CCG had been formed from the merger of Lancashire North and South Cumbria and many GP practices had also recently merged. Earlier work by the vanguard on respiratory care also appears relevant to the experiences of the new model; prior to the formation of the MBRN, an earlier service redesign process was initiated. This earlier model focused more on secondary care and was not implemented. The time involved in its development however appeared to affect interviewees' initial willingness to engage with the subsequent change initiatives.

- The first phase of the evaluation fieldwork has focused on exploring the experiences of staff involved in designing the MBRN model and implementing the bundle 1 activity package. Bundle 1 has involved the introduction of monthly MDTs in the North Lancashire and Barrow localities, and the appointment of a GP lead and wider ICC respiratory team in five ICCs. As the data collection is ongoing, interviews with representatives from these teams will continue into the second phase of the evaluation. Therefore, the emerging findings do not necessarily reflect how the model has been implemented across bundle 1 activity areas; instead they provide some insight into how it is working in a narrow range of contexts.

- The design of the new care model, and the change management process more broadly, appears to have been based on dialogue and engagement rather than more formal project management methods. For those interviewees who had previously committed time to earlier redesign initiatives, the willingness of the MBRN to learn from their expertise was key to securing their participation. Interviewees reported feeling that they were being listened to

and valued. Many of the features of the MBRN approach resonate with the concept of a collective leadership culture, which refers to how a vision for change is passionately communicated and leadership power is shared with those involved in its delivery (West et al., 2014).

- Some interviewees referred to the change brought about by the new respiratory model as a point of distinction from their previous experiences of service redesign initiatives. Because of these experiences, interviewees were initially wary of contributing to another such initiative. The MBRN's approach to engaging staff overcame these reservations and led to the participation of hospital, primary and community care services. However, it is important to acknowledge that investment in community respiratory services is planned for bundle 2 and therefore, for some staff working in the community, the model had yet to bring about any changes to their way of working.

- Clinician or managerial buy-in also emerged as a key enabler. Where managers were supportive of the new model, clinicians were able to adapt their working day to accommodate the additional workload. Interviewees observed that in ICCs where there was perceived to be little managerial buy-in, staff were working on their day off to enable the model to be implemented.

- Interviewees' reaction to the introduction of MDTs was overwhelmingly positive. Staff described how the in-depth discussions of patient cases were removing barriers to communication between primary, secondary and some community care services. The MDTs appear to be open to the expertise of any staff member involved in a patient's care. In doing so, those attending MDTs were able to access a wide range of expertise, which in turn was upskilling staff. Although different specialities and clinical roles contributed to this learning process, it appeared that the attendance of a respiratory consultant was key. The consultant's approach to reviewing x-rays and other diagnostic tests in the MDTs was cited as being particularly valuable to staff. The learning process has been further supported by the provision of training activities for GPs and nurses and the provision of written protocols. Interviewees expect that the upskilling of ICC respiratory staff will reduce the number of referrals to outpatient clinics.

- Capacity for change is another important determinant of the new respiratory care model's implementation. As with wider vanguard activities, interviewees were developing and implementing the new model alongside the existing requirements of their role. This meant that staff were often attempting to change working practices when there was little or no capacity to do so. The available interview data suggests that capacity varied across the bundle 1 area; for example, some larger practices were able to backfill the time nurses spent on the model's delivery using existing practice staff. However, it was reported that for capacity to be increased more widely, the urgent care cycle first needs to be broken. The vanguard funding appears to have facilitated this for some and has been used to finance the additional working hours required. Some interviewees reported that they would not have been able to engage with the service redesign in the absence of this funding. However, for

those roles not financed by the vanguard, the implementation of the model appeared to be reliant on the commitment and goodwill of staff.

- The timeline for the initial bundle 1 roll out was perceived to be challenging and some staff would have benefited from additional lead in time. In addition, the timeline available to demonstrate outcomes was also testing. The bundle 1 roll out began in October 2017 and evidence of its outcomes were to be reported in February 2018 to inform decisions on its future investment. Interviewees felt that it was difficult to achieve all the potential outcomes in this short period. Uncertainty over its future investment, and the non-recurrent nature of vanguard monies, was thought to have affected how some staff responded to the change process (they held off implementing some elements until a continuation of its funding was agreed).

- As the evaluation fieldwork was carried out during an early stage of the model's implementation (January – April 2018), interviewees generally felt that it was too soon for many outcomes to be evidenced. However, all were able to describe the outcomes they expected to be achieved, which included: improved diagnosis and care management, a reduction in secondary care activity, improved productivity and improved staff and patient experiences.

- The increased communication between staff and the upskilling of staff was expected to improve the speed, accuracy and quality of diagnosis. Indeed, a few interviewees cited examples of how some diagnoses had already been altered as a result of MDT case reviews. In turn, an improved approach to diagnosis was thought to be improving condition management and the multi-disciplinary approach to its management facilitating more joined up care. These changes were attributed to staff feeling better supported, more confident and experiencing increased job satisfaction.

- The improved diagnosis and disease management were also expected to benefit patients. Other unexpected patient outcomes were also highlighted; one interviewee felt that the joined up approach to care brought about by the MDTs was increasing patients' trust and confidence in the care system. Patients will be interviewed in the second phase of the evaluation to explore how their experiences of care have been affected by the new model.

- The premise of the model is that as patients are increasingly managed in the community, demand for secondary care will decrease and hospital beds closed. Although it was recognised that more complex patients would still require a referral, it was generally thought that one MDT case review equated to one less outpatient appointment. It is anticipated that the respiratory dashboard currently being developed by the Informatics, Information and Innovation team at University Hospitals Morecambe Bay Trust will allow changes over time to be determined. In its absence, the local evaluation team have been provided with new GP referral data for both bundle 1 and bundle 2 ICCs. This data shows that while the number of new referrals were higher in bundle 2 ICCs between October 2017 and January 2018 (relative to the equivalent period in 2016/17), there was a lower number of referrals in bundle 1 ICCs

over the same period. The available qualitative data would support the attribution of the bundle 1 reduction in new referrals to the implementation of the new MBRN model of care. Further interrogation of this data will take place upon the release of the new respiratory dashboard.

- Additional investment in community respiratory services was perceived as being necessary to reduce non-elective attendances and bed days. For example, an increased number of specialist clinicians could improve the support available to patients to better manage their condition. By supporting patients to improve their understanding of their breathing patterns and recognise the signs of an exacerbation, it was thought that patients would experience less anxiety and therefore be less likely to present at A&E.

- These changes were thought to be creating a more efficient approach to diagnosis and care management. The MDT was attributed to offering more value for money by enabling more patients to be reviewed in a shorter period of time than in traditional outpatient clinics. In addition, an increasingly upskilled ICC respiratory team was expected to reduce diagnostic tests and scans as well as outpatient appointments. An economic impact assessment will be conducted in the final phase of the evaluation to explore the cost-effectiveness of the new way of working.

Interim Conclusions and Recommendations

- The themes presented in this report will be reviewed and refined as the qualitative data collection continues and a broader range of experiences and perspectives explored. Importantly, in the final phase of the evaluation, the qualitative data will be triangulated with the quantitative data provided in respiratory dashboard and the model's economic impact assessed.

- The available data indicates that there is strong support for the new way of working, much of which can be attributed to the MDTs and their success in breaking down the barriers to communication and upskilling staff, which in turn has led to an improved staff experience. The MDTs are also expected to lead to improved patient outcomes by improving the accuracy, speed and efficiency of diagnosis and care management more generally. This appears to have already led to a reduction in new outpatient referrals.

- However, additional investment in community respiratory services is required to reduce non-elective attendances and bed days. Specialist respiratory nurses, improved access to pulmonary rehabilitation and patient education were all identified as capable of contributing to reduced secondary care activity.

- The specific qualities of those leading the MBRN appear to be important to the model's achievements to date. There has been a willingness to engage with and learn from staff across secondary, primary and community care to achieve higher quality respiratory care.

- Based on these findings, the MBRN and wider BCT partners may like to consider the following points in their discussions on the future roll out of the new respiratory care model:

    - The openness and willingness to engage with staff should be maintained as the model is scaled up across Morecambe Bay. A particular challenge will be whether or not the particular qualities of those leading the MBRN can be replicated by those engaging in its wider roll out. Increased capacity will be required to ensure that its roll out is managed effectively and is not reliant on the goodwill and commitment of key staff.

    - The partial implementation achieved to date has constrained the ability of the model to reduce secondary care activity. However, future investment decisions will be based on its success in achieving such reductions. Evidence based funding decisions should be based on metrics that reflect a model's logic chain to ensure that they are appropriately evaluated.

    - The vanguard monies have enabled several components of the MBRN model to be tested in Morecambe Bay. However, as a non-recurrent funding stream, it has also created uncertainty over its future. Effective succession planning is therefore necessary to ensure a seamless continuation of services after a fund has ended.

    - Given the demands on health staff and their capacity to respond to them, future service redesigns should ensure that there is adequate lead in time. This will enable staff to better align their working practices to accommodate the requested changes.

Next Steps

- Based on experiences of this first phase, it is recommended that the following objectives are addressed in the remainder of the evaluation:

    - Establish how the new respiratory care model has been implemented in a wider range of contexts through further interviews with staff involved in bundle 1, 2 and 3 roll outs;
    - Explore how the implementation of the new model is scaled up and if a collective leadership culture is replicated in this wider roll out through further staff interviews;
    - Explore what features of the MDTs are critical to breaking down communication barriers and upskilling staff through observations of MDTs in each locality;
    - Explore patients' perceptions of changes in respiratory care and how they have been affected by these changes through in-depth interviews with those patients that have interacted with the new model;
    - Triangulate the qualitative data with the quantitative data presented in the new respiratory dashboard;
    - Use the data presented in the new dashboard to assess emerging respiratory outcomes against the model's KPIs; and

- Assess the economic impact of the new respiratory model (the scope of this assessment will be determined by the availability of input data; the evaluation team will continue to explore how time spent on respiratory care has been affected by the new model in the staff interviews).

By addressing each of these objectives, the evaluation's overarching aim will be achieved: to determine what context, mechanism and outcome configurations explain what works for who and in what circumstances.

Contents

1 Introduction

1.1 Background

In 2015, 50 vanguard sites were selected to develop new models of care. The new care models (NCMs) were a key component of the strategy set out in the *Five Year Forward View*[1] to prevent widening gaps in health and wellbeing, care quality, and funding and efficiency. Morecambe Bay's Better Care Together (BCT) programme, a partnership set up in 2012 to review health services, was selected as one of these vanguards. As an integrated Primary and Acute System (PACS) vanguard, it aimed to:

- Improve primary and acute medicine; and
- Develop preventative community-based services.

Evaluation is a key component of all NCMs and NHS England established a national NCM team to ensure that the learning from each vanguard was shared throughout the NHS. In addition to a national evaluation, which is measuring performance against a core metric set, each vanguard was required to commission a local evaluator to identify why and how impacts are being created. Health and Social Care Evaluations (HASCE) at the University of Cumbria was commissioned by University Hospitals of Morecambe Bay NHS Foundation Trust to evaluate the BCT PACS vanguard.

The local evaluation focuses on understanding the context of the programme, the changes it has brought about, and which components of the care model really make a difference. The evaluation begun in 2016 and it is now in its second year. This report presents the findings emerging from this second year and in doing so, builds upon the evaluation findings previously set out in the 12 Month Report[2]. A final evaluation report is due to be published in Autumn 2018.

1.2 About BCT

The BCT programme brought together 12 partners (now 10, following the merger of two Clinical Commissioning Groups and recent transfer of CPFT staff into UHMB in April 2018) to tackle the challenges facing the provision of health care in Morecambe Bay. These challenges included an ageing population, increased demand on resources, finance and issues with care quality and safety. BCT identified a population based approach as key to improving care and promoting wellbeing[3] and achieving the *Five Year Forward* Triple Aim:

- improving population health;
- improving the individual experience of care; and

[1] NHS England (2014). *NHS Five Year Forward View. https://www.england.nhs.uk/publication/nhs-five-year-forward-view/*

[2] HASCE (2017). *Local Evaluation of Morecambe Bay PACS Vanguard. 12 Month Report.*

[3] *The Better Care Together Strategy for the Future for health and care services in Morecambe Bay*. (2015) https://www.uhmb.nhs.uk/files/bct-publications/Better-Care-Together-Plan.pdf p.6

- reducing per capita health and care spend.

In 2015, BCT was allocated £4.59 million to develop the PACS new model of care. The PACS model is based on GP registered population and aims to bring together health and care providers to improve physical, mental, social health and wellbeing. Its scope includes primary, community, mental health, social and acute care.[4] Key features of the BCT vanguard approach include:

- the establishment of 12 Integrated Care Communities (ICCs) (now 11 as Garstang has realigned with FWCCG) that bring together local health and care organisations. The ICCs are based on GP practice populations and, through integrating services, aim to enable the provision of more care out of hospitals and self-management;
- the use of technology, such as telehealth, to increase the accessibility of care amongst more isolated groups and communities;
- increasing GP access to hospital specialists through the Advice and Guidance system;
- work with local communities through initiatives with children and outreach work at public events; and
- using a workstream approach to develop new models in areas such as ophthalmology, Women's and Children's services and prescribing.

As described in Section 2, the first year of the evaluation collected qualitative data on activities across the vanguard to explore the emerging changes and their associated outcomes. The focus in the second year of the evaluation has shifted onto specific interventions to allow for more in-depth and nuanced analysis of what is working for who and why. At the request of BCT partners, Year 2 evaluation focuses on the new model of respiratory care developed by the Morecambe Bay Respiratory Network (MBRN).

1.3 A New Model of Respiratory Care

As described in the case for change document presented to the Morecambe Bay Accountable Care System's Delivery Group in August 2017[5], the MBRN sought to deliver a new model of care "*to proactively and consistently manage respiratory disease to a high standard across Morecambe Bay.*" . The MBRN's analysis of Right Care data packs concluded that Lancashire North and Cumbria performed poorly in terms of both costs and clinical outcomes when compared to similar areas. By releasing activity and costs from secondary care, the MBRN was intended to develop a new model of respiratory care. The key goals of the new model are:[6]

- flexible network model allowing each ICC to develop their own way of working;
- all patients will be diagnosed accurately to establish the nature of their respiratory condition;

[4] https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf

[5] MBRN (2017). *Morecambe Bay ACS Case for Change in Respiratory Services, p.1.*

[6] MBRN (2017). *Morecambe Bay ACS Case for Change in Respiratory Services,* p.1

- patients with respiratory conditions should have all their routine care provided and managed within ICCs – the aim is to reduce outpatient attendances by 50-100% by the end of 2018;
- all patients will have a personal care plan that is understood and owned by the patient/carer;
- all patients will have an annual review as a minimum (whole person Multi-Disciplinary Team (MDT) based review);
- high quality care will be provided by an extended MDT in each ICC, combining the appropriate expertise from both secondary and primary care;
- patients with exacerbations should also be managed within ICCs in the vast majority of cases – aim to reduce non-elective attendances by other 50% by the end of 2018; and
- the opportunity for UHMB to develop additional specialist clinics to repatriate care for difficult asthma currently being seen out of area.

At the centre of the model's design was the development of a community clinic and hospital at home service.[7] The clinics were to bring consultants and specialist nurses out of the hospital and into the community to work with ICC staff. It was expected that this way of working would enable secondary care staff to support and mentor ICC staff. Multi-disciplinary team (MDT) discussions were to be built into the clinics, with patients being discussed rather than referred to an outpatient clinic. As shown in Figure 1 below, the improvements to respiratory care required investment in three separate components.

[7] This description of the MBRN relates to the design presented in the Case for Change documents. Section 2 provides details of which components have been implemented to date.

Figure 1: Key Elements of the MBRN Respiratory Model[8]

ICC Respiratory Team	Community Clinics	Locality Based Services
• ICC respiratory teams to be established, headed by a lead GP • Supported by a secondary care link team (to be established for each of the localities in Morecambe Bay) • Lead GP to have direct access to consultant and nurse specialist and secondary care investigations • Consultant and respiratory nurse to provide education and support to ICC staff (alongside lead GP) • Consultant, nurse specialist and lead GP to attend monthly Community Clinics	• To be developed after MDT is established • To review patients with uncertain diagnosis and/or who need secondary care input • ICC staff to refer deteroriating patients for rapid access • Follow up patients with recent admissions or exacerbations • MDT discussion of cases • Facilitate ICC staff education	• Enhance pulmonary rehabilitation capacity • Reintroduce post pulmonary rehabilitation exercise programmes

The overall vision was to be led by a new Respiratory Leadership Group, formed of ICC GP Leads, secondary care specialists, pulmonary rehabilitation representatives and others. It was also expected that the MBRN would include Home Oxygen Services and a review of the respiratory formulary for asthma and COPD. The implementation of the model was planned in three bundles of activity; in the first, the model would be implemented by GP and community services in five ICCs (Barrow Town, Queen Square, Lancaster, Morecambe Bay and Carnforth); the second bundle would see the model being rolled out in GPs and community services in the remaining six ICCs (Kendal, East, Alfred Barrow, Millom , Ulverston, Dalton and Askam, and Grange & Lakes); and then specialist respiratory and acute bed capacity would be reduced in the third activity bundle. This phased approach to the implementation has informed the evaluation design, which is discussed further in Section 2.

1.4 About this Report

This report presents an interim summary of the MBRN evaluation work conducted so far and the emerging findings on the change and impact of the bundle 1 roll out. This serves both to continue and develop the evaluation approach detailed in HASCE's 12 month evaluation report,[9] and inform discussions on the future investment in the new respiratory care model and its wider roll

[8] Source: Adapted from MBRN (2017). *Morecambe Bay ACS. Case for Change in Respiratory Services*

[9] The 12 month report was completed at the end of the first evaluation stage, in October 2017.

out. In doing so, the interim report follows the spirit of the vanguard approach: regular sharing of evaluation findings to inform and strengthen delivery.

In addition, the national NCM team are collating evidence from across all the local evaluations. This evidence will be shared across the NHS so that key learning points can be disseminated. To this end, this report should be read in conjunction with HASCE's 12 month evaluation report.

The remainder of this report is structured as follows:

- Section 2 summarises the approach to the evaluation in year 2 and provides an update on the progress to date;
- Section 3 presents the emerging findings on the changes brought about by the MBRN, the mechanisms that have enabled and disabled them, and perceptions of outcomes;
- Section 4 presents the interim conclusions that have been drawn from these findings and a series of recommendations for both the future delivery of the MBRN and evaluation.

2 The Evaluation Approach

2.1 Introduction

A detailed description of the evaluation approach was provided in the 12 Month Report[10] and is therefore not repeated here. Instead, the key features of the methodology are summarised, along with an update on the progress of the year 2 evaluation.

2.2 A Realist Methodology

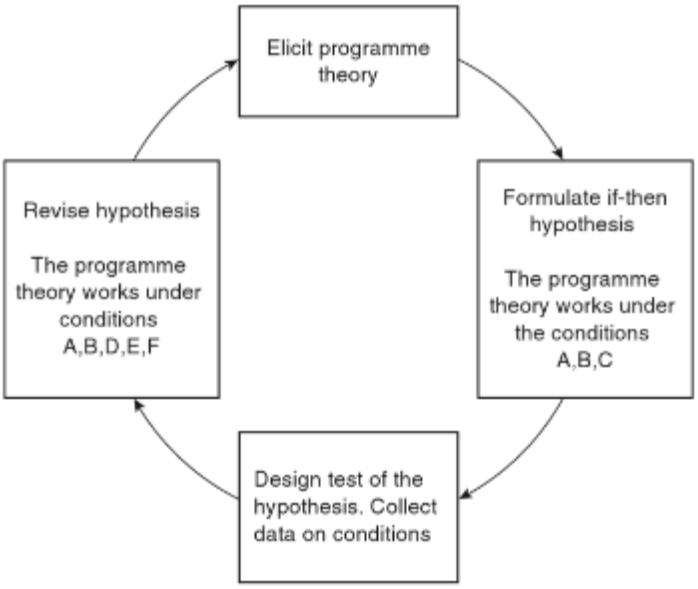
Like all local evaluations of NCMs, HASCE's approach is designed to address the question set developed by the national NCM team. These questions require an assessment of the context, changes, outcomes and active ingredients of the NCM. To do this, a realist methodology has been adopted.[11] This approach aims to capture 'what works, for who, and why', in nuanced detail, over and above blunter outcome-focused studies. It does this by identifying the context, mechanisms and outcomes associated with programmes of change. The basic premise of this methodology is that outcomes are brought about by the steps taken by those delivering a programme (known as mechanisms), which take place in particular contexts.

The aim of evaluation then, is to investigate which context, mechanism and outcome configurations explain what works for who, in what circumstances and how. The realist approach involves a process of testing to refine these configurations (sometimes referred to as 'programme theories'); this is known as the realist feedback loop. As shown in Figure 2 below, this loop begins with the programme theory (or the logic chain), which provides a context, mechanism and outcome statement that describes what works under what conditions. This process aims to provide an understanding of causality. The first loop was completed in year 1 of the evaluation and year 2 aims to refine and adjust the emerging theories through a further loop.

[10] HASCE (2017). *Local Evaluation of Morecambe Bay PACS Vanguard. 12 Month Report.* Chapter 2

[11] See Pawson & Tilley, *Realistic Evaluation*. London: SAGE (1997).

Figure 2: Realist Feedback Loop



In addition to its attention on the contextual details that affect the success of interventions (or otherwise), a key advantage of this method is how it accounts for how the delivery of an NCM often depended on a number of overlapping and interconnecting processes taking place. Models for change can suffer setbacks at various stages in their implementation, and it is important to identify the 'active ingredients' which support new models of care, some of which may not be immediately apparent. To demonstrate this, the 12 month evaluation report presented an expanded version of the realist method.[12]

2.3 Year 2 Data Collection and Analysis

This methodology has guided the development of three main evaluation components, which are:

- Qualitative data collection and analysis;
- An economic impact assessment; and
- Triangulation with quantitative data provided by the Informatics, Information and Innovation (I^3) team at University Hospitals of Morecambe Bay Trust.

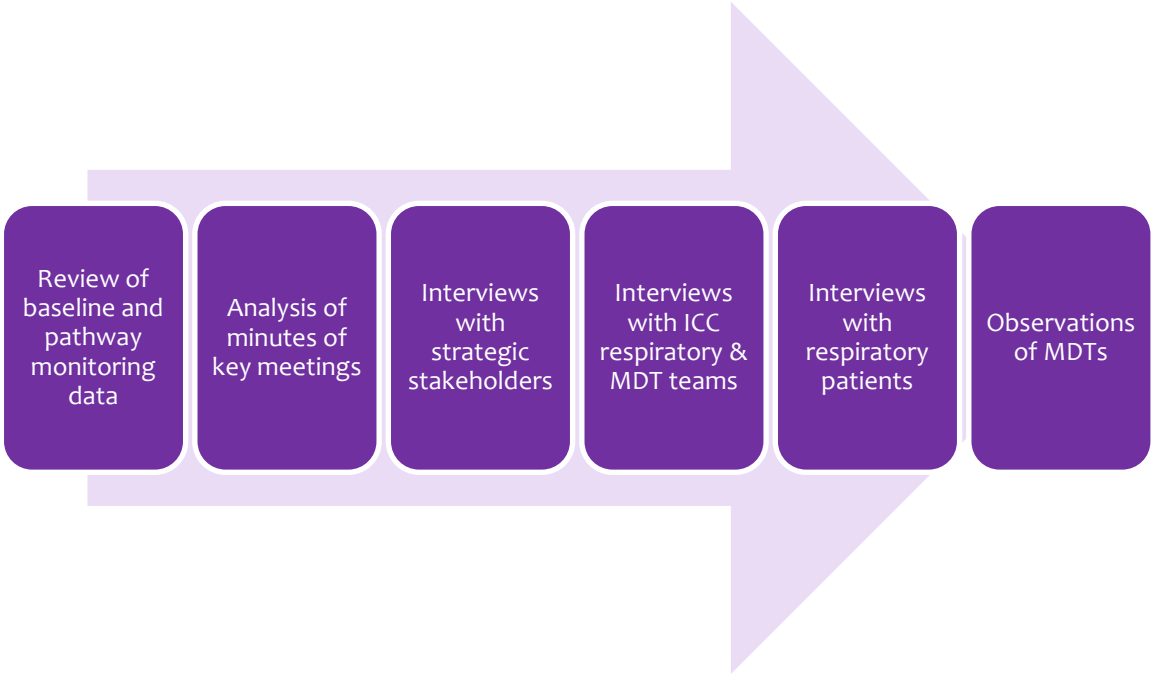
Each of the components were completed in year 1 and will be repeated in year 2.

Following discussions of the findings emerging from year 1 of the evaluation, it was initially agreed with the evaluation commissioners that the second year of the evaluation would begin in October 2017 and focus upon three pathways (respiratory, paediatrics and frailty) in three ICCs (Barrow Town, Bay and East). However, following the wider re-focusing of Bay Health and Care Partners' activities, it was agreed at the BCT Research and Evaluation Group that concentrating

[12] See HASCE (2017). *Local Evaluation of Morecambe Bay PACS Vanguard. 12 Month Report,* Chapter 4

evaluation resources on the new respiratory model of care across a greater number of ICCs would provide opportunities for learning. An evaluation of this new model began in January 2018 and, reflecting the staggered approach to the roll out of this model, the evaluation consists of two phases. The first evaluation phase is exploring the roll out in the bundle 1 ICCs and the second phase the roll out of bundle 2 and 3 activity. This report presents the findings emerging from the first of these phases and will be used to inform discussions on the approach adopted in the second phase. Figures 3 summarises the data collection activities planned in this phase.

Figure 3: Summary of Year 2 Data Collection



Further details on each of these planned activities and our progress against each is summarised in Table 1 below.

Table 1: Data Collection Activities and Progress Summary (Phase 1 of Year 2 Evaluation)

Data Collection Activity	Progress Update
Review of baseline and pathway monitoring data Key respiratory data metrics and indicators are being collated into a new respiratory dashboard by the Informatics, Information and Innovation team at University Hospitals Morecambe Bay Trust. The dashboard will present the data required to assess the new care model against its key performance indicators (KPIs). This data will be triangulated with the qualitative data collected by the HASCE evaluation team.	At the time of writing this report, the KPIs are still in development and the latest working version of the dashboard has not been released to the evaluation team. It is understood that this will happen in May 2018. Therefore, the intended triangulation of data has not been conducted.

Data Collection Activity	Progress Update
Analysis of minutes Records of who attended meetings, discussion points and agreed actions provide a potentially valuable source of data on how the new respiratory model has been developed and delivered across primary, community and secondary services. Meetings that are potentially relevant to the evaluation include the Bay-wide Respiratory Leadership Group and ICC meetings.	The Respiratory Leadership Group has not yet formed and minutes for ICC meetings in Barrow Town and Queen Square have been received for the months of October, November and December 2017. There were few references to the respiratory care model in these minutes and they therefore provide little insight into the development and delivery of the new model.
Interviews with staff (strategic stakeholders, ICC respiratory teams and MDT teams) Interviews with those involved in the development, leadership and delivery of the respiratory pathway will be conducted. This will include those involved with its strategic delivery and leadership and the MDT teams in each of the bundle 1 ICCs included in the evaluation. The purpose of these in-depth qualitative interviews is to explore the process of developing and delivering the new respiratory pathway and perceptions of its impact. The topics explored in the interviews are shown in Appendix 1.	37 staff members identified by the MBRN as being involved in the delivery of the new model of care have been invited to participate in an interview (the first invitation was issued in January 2018). 17 interviews have been completed between January and April 2018. The interviews have ranged between 15 and 70 minutes in duration. Clinicians have reported shorter interview times reflecting limited availability during the busy winter period. With the permission of participants, interviews were audio-recorded and then transcribed. Eight people have declined the invitation to take part in an interview. Reasons given for non-participation include lack of knowledge or involvement in the MBRN, lack of time or change in job role. Seven interviewees have represented an ICC respiratory team but interviews have not yet been conducted with representatives from all bundle 1 teams.
Interviews with patients In-depth qualitative interviews will enable exploration of experiences of care and the perceived impact of the changes brought about by the new pathway on satisfaction, self-management, and health and wellbeing.	It was identified that only small numbers of patients had interacted with the new respiratory model when the phase 1 fieldwork commenced. Patient interviews have therefore been postponed until May 2018. The invitation to participate will be disseminated via gatekeepers (respiratory clinicians).

Data Collection Activity	Progress Update
Observation of MDTs The data collection activities planned for the first phase were recently extended to include observations of the MDT meetings. The emerging interview findings indicate that the MDTs play an important part in reducing outpatient appointments and in the management of respiratory care more generally. Observation of these meetings will enable exploration of what features are key in enabling/disabling the new care model.	A request to observe an MDT was submitted to the MBRN's lead clinicians in April 2018 and it is expected that observations will take place in May and June.

The available interview data has been analysed thematically using the qualitative analysis software package Atlas.ti. An initial coding framework was developed by two researchers and then applied to each transcript by these researchers. In the initial stages of the analysis, both researchers analysed the same transcripts and then the codes used were compared to identify areas of convergence and divergence in the application of the coding framework. Where the codes were used differently, the definition of each code was refined to achieve agreement on its meaning. This approach represents good practice in qualitative analysis and strengthens the reliability of the analysis process.

The themes emerging from the data were then organised into context, mechanism, outcome and resource themes. This has been used to formulate emerging theories of causality at this interim stage. The data analysis will continue as the year 2 evaluation progresses to refine and continue testing these theories.

The evaluation adhered to an ethical code of research conduct throughout the project. Where appropriate, data collection and analysis was approved by the University of Cumbria's Research Ethics Committee.

3 Emerging Findings

3.1 Introduction

To date, 17 interviews with staff involved in the design or delivery of the new respiratory model of care have been conducted. The emerging themes from these interviews are summarised in this section of the report. It begins with a discussion of the key contextual factors relevant to the MBRN's implementation and then reviews the changes that have been brought about by the MBRN and importantly, what factors have enabled or disabled the process of change. Consideration is then given to the available evidence on the emerging outcomes and future changes.

3.2 The MBRN Context

Understanding the context in which any intervention is implemented is an important step in realist evaluations. Context includes historical, cultural, organisational or other factors that may support or inhibit an intervention. While the MBRN is situated within the broader context of the BCT landscape described in the year 1 evaluation report,[13] year 2 data so far suggests that the following specific factors are relevant to the MBRN's context of delivery:

- disease prevalence and the capacity of services to meet care demands;
- historical issues with care quality;
- previous initiatives; and
- organisational restructuring and staff shortages.

3.2.1 Disease Prevalence and Service Capacity

It is expected that the new dashboard will provide a detailed understanding of the prevalence of different respiratory diseases across Morecambe Bay. However, in its absence, Quality and Outcomes Framework (QOF) recorded disease prevalence data has been used: there are 24,189 patients in the Morecambe Bay CCG area with asthma (prevalence 6.77%) and 7,818 with Chronic Obstructive Pulmonary Disease (COPD) (prevalence 2.2%). The prevalence for both these diseases is higher than that in England (5.91% and 1.85% respectively).[14]

Some interviewees commented on the high prevalence of respiratory disease across Morecambe Bay and felt that secondary, primary and community care services lacked the capacity to respond

[13] See HASCE (2017), *Local Evaluation of Morecambe Bay PACS Vanguard: 12 Month Report*, pp.45-59. The high-level contextual themes were identified in this report as: Geography and Demographics (diversity of physical geography and socioeconomic contexts of delivery); Skill Supply (problems with recruitment and retention of staff); Previous Interventions (disillusionment with change); Organisational Cultures (silo working); and Availability of Resources.

[14] Lancashire County Council (2017). *Morecambe Bay CCG Mini Summary Profile 2017/18.* http://www.lancashire.gov.uk/media/898216/morecambe-bay-mini-summary-profile-2017-18.pdf

to the demands associated with this, which in turn affected the quality of care provided. For example, one interviewee described how long waiting lists affected care quality:

> *"Certainly, in the outpatients we have a large waiting list of patients who are past their indicative review date. They should have been seen in three months and it is six, or nine months later and they're coming in. Which causes problems in giving the best care".* (LB-18-CL-H-25012018)

Related to this, timely discharge was perceived to be prevented by a lack of capacity in primary and community care services.

> "*I think the key issues in terms of respiratory is the level of capacity within the hospital and out in primary care to manage those patients."* (SS-18-PR-H-05022018)

The increased demand for respiratory care in winter and the inability of services to respond to it was also highlighted:

> *"Normally we'll get about 25 [*referrals*] a week, but over winter you are looking at 20 a day. We can't keep up with all of that."*(SS-16-CL-H-15022018)

Some interviewees linked the prevalence of respiratory disease to the industrial heritage of some parts of Cumbria, while others also emphasised the links between deprivation and respiratory disease or the ageing population more generally. For example:

> *"Previous industries around high levels of COPD respiratory infections are quite high and we've also got quite deprived areas, certain areas of the Barrow area and a high level of elderly, frail patients that obviously suffer from respiratory infections. That obviously places demand for our services within respiratory. Whilst there is some community level provision in terms of managing those pathways out of hospital, they are currently insufficient to meet demand."*(SS-18-PR-H-05022018)

> "T*he prevalence of all respiratory diseases is going up. Certainly, in the South Lakes, the ages of our patients are going up, as well as the increase in the prevalence of the respiratory diseases. They are becoming more frail with their respiratory disease. We can't treat who is being referred to us, never mind who is going to be referred to us in the next 12 months."* (BCT-SS-16-CL-H-15022018)

The geography of Morecambe Bay was also thought to affect respiratory care. As reported in the 12-month report, some parts of the footprint are geographically isolated, which makes access to specialist services more difficult. For example, one interviewee described how patients in Barrow were travelling to Preston and Manchester, which was particularly challenging for older or frail patients.

3.2.2 Historical Issues with Care Quality

Interviewees commonly described inefficiencies or variations in standards of care when explaining why a new model for respiratory care was needed. The quality of diagnoses, the rationale for referring patients to secondary care and the timeliness of discharge were all identified as factors affecting care quality.

Before discussing these factors, it is important to acknowledge that interviewees felt that issues with care quality differed across Morecambe Bay. Care was reported as varying not only across the footprint, but also within ICCs and even practices.

> *"What respiratory patients are being offered across the Bay differs, depending on where they live or what GP they are registered with."* (SS-16-CL-H-15022018)

Interviewees described how the capacity of care teams to meet the needs across the Bay differed. For example, unlike in North Lancashire, there were no long-term condition matrons or oxygen services in South Cumbria. Another commented that locum staff had provided respiratory care at the Furness General Hospital for some time, which was perceived to have created communication difficulties with secondary care. In contrast, some primary and community care staff felt that they had established effective communication systems:

> *"Patients are actually getting what they need* [in our area]. *Part of that is because I think we've worked very hard as a team to improve communications with secondary care."* (SS-16-CL-H-120220108)

Reflecting observations such as these, communication was identified as another barrier to achieving care quality. Resonating clearly with findings in HASCE's 12 month evaluation report, lack of communication meant that there was some duplication in care and a lack of understanding amongst patients:

> *"We need to improve communication. Like I say, we work in silos. So, we might see a patient in clinic, a week later they might go to the same appointment in GP land, with the practice nurse, and we've already done it."* (SS-17-CL-H-06042018)

> *"Communication is probably the absolute issue. I've had a patient this morning who… said he'd got an appointment at the hospital. He said 'what's it for?' and I said, 'I don't know'… He said 'I don't know who's doing what. It's my body but I don't really know what's happening.' He didn't even know who is making the decisions. That's really confusing for him."* (SS-16-CL-H-12022018)[15]

Issues with diagnosis were also reported; one interviewee suggested that the capacity of primary care staff needed to be increased to address this:

[15] See HASCE (2017), *Local Evaluation of Morecambe Bay PACS Vanguard: 12 Month Report*, pp.172-73 for a wider discussion on how communication, decision-making and perceptions of quality of care are linked.

> "*There hasn't really been the investment and the development in primary care to manage respiratory conditions. Because of that, we've got poor diagnosis, so you've got asthmatics coded as COPD and vice versa, you've got people coded as breathless or wheezy or cough, so diagnosis needs sorting out.*" (SS-17-PR-H-19022018)

Interviewees emphasised the importance of diagnosis to effective treatment and care planning, without this patients were exacerbating and presenting at hospital.

> "*… patients with respiratory diseases, they are not always diagnosed consistently or accurately, which impacts our ability to provide effective care planning. Without a good care plan, patients can't manage their own condition, the medication can be ineffective and that leads to further exacerbation of their conditions.*" (SS-18-PR-H-05022018)

The wider structure in which general practice manage care also emerged as an important contextual theme affecting the quality of diagnosis. As one interviewee described, the Quality and Outcomes Framework (QOF) provides a single code for some respiratory conditions and does not differentiate between disease sub-classifications. This again, prevented the implementation of effective care plans.

Other interviewees thought that the QOF could also inhibit the effectiveness of care management and described how once entered into the QOF system, patients then receive regular reviews - most commonly by practice nurses. This nurse-led system of care was attributed to the erosion of GPs' respiratory knowledge, which left nurses without a source of advice:

> "*It's the nurses that are seeing all of those and the feedback that we have got is that they do feel quite unsupported. The GPs have almost become out of practice in interpreting respiratory function tests and the diagnostics, because it's more protocolised* [sic] *and nurse-driven. Nurses are becoming the experts, but they don't have the back-up of all that in-depth training.*" (LB-18-CL-H-25012018)

> "*Generally, nurses know more about these diseases because they do it more often than GPs. They needed someone to go to, they didn't have that before and they have that now* [with the implementation of the new model of care]. *We would typically not pick up deteriorating disease, because the nurses weren't confident enough to do that and there was no GP seeing them. You would just get people constantly coming in for reviews every year and then they'd pop into hospital, get admitted at some point…* " (SS-11-CL-H-23012018)

Issues with the quality and consistency of referral pathways were also mentioned; interviewees questioned if the right patients were being referred to outpatient clinics and identified clinician's knowledge as a critical factor that determined if and when a referral was made.

> "*It depended a little bit on the knowledge that the practitioners had as to how far that person would go with the patient. They would always refer on if they weren't sure, but they would probably refer onto the GP, who probably had – they won't mind me saying this, but*

probably less knowledge than the Practice Nurse had in the first place." (LB-10-CL-H-13022018).

A lack of robust pathways was also attributed to unnecessary referrals:

> *"I think a lot of our pathways weren't necessarily that robust if I'm honest, in terms of guiding GPs into referring the right people, or what they could do in advance."* (LB-18-CL-H-25012018)

Reflecting these issues with care quality, respiratory care was generally perceived to be inefficient, which is supported by NHS Right Care Data. The MBRN's Case for Change document summarised key areas of poor performance, which included: high elective, non-elective and prescribing spend across all respiratory conditions; a COPD mortality of less than 75; asthma adult and under 18 year admission rates. The MBRN concluded that "*costs and clinical outcomes are worse in both Lancashire North and Cumbria when compared to other similar areas."* (p3[16]).

3.2.3 Organisational Change and Staffing

As highlighted by interviewees, it is important to acknowledge that the new model of respiratory care is, like all vanguard activities, being implemented during a period of organisational change. Key changes include the merger of Lancashire North and South Cumbria to become Morecambe Bay CCG in April 2017. In primary care, many GP practices have recently merged and although the merge may be complete, the process of reorganisation was still thought to be ongoing for some. In addition, staff shortages continue to be an issue in some areas in both primary and secondary care. Interviewees reported that ICCs were experiencing GP shortages, which one interviewee attributed to a combination of practice mergers and retirement, and that there had been four vacant acute respiratory posts for over three years.[17]

3.2.4 Previous Initiatives

Redesigning respiratory care has been subjected to much discussion in Morecambe Bay in recent years. A new model of care was first presented to the BCT vanguard for consideration in 2015 (prior to the formation of the MBRN). This earlier model was described as focusing more on secondary care, which left some community service providers questioning their role within it:

> "*There seemed to be various stakeholders that had different agendas; primary care were really looking for more of a ground-up investment, emboldening primary care to do more. Whereas I think they saw the proposals as more secondary care, just moving out and working in a different place and not necessarily truly integrating care… I think some of our community partners also felt that perhaps there wasn't a focus on expanding their services."* (LB- 18-CL-H-25012018)

[16] MBRN (2017). *Morecambe Bay ACS. Case for Change in Respiratory Services.*

[17] See also HASCE (2017), *Local Evaluation of Morecambe Bay PACS Vanguard: 12 Month Report*, pp.50-51 and pp.139-141 on staffing contexts across Morecambe Bay.

> *"That was incredibly secondary care focused. We would end up being the tag-along kind of community thing, but there was almost a feeling of what's the point, if we aren't really going to have a say. Actually, a lot of the things that they decided to do, were around how could they be more efficient from a hospital end. That was about patients initiating follow-ups and all of that work, which to be honest, you came away thinking, "why couldn't they do that anyway? What's that got to do with us?"* (SS-16-CL-H-12022018)

Experiences of this earlier model were often used as a point of reference by interviewees and frequent comparisons were made between the approaches to developing the two models. A fundamental point of difference was the lack of funding secured by the 2015 iteration and therefore no changes were made to respiratory care. Several interviewees had attended meetings as part of the development of this earlier model and the lack of return on their investment was a source of frustration.

> *"The first round of BCT took enormous amounts of my time out of practice. We did it because it was really important. That went nowhere."* (SS-16-CL-H-15022018)

> *"Initially it was like a stream that was running. We were excited, there was movement and activity, it was engaging, and then it became a swamp and nothing happened. It got to the point where people stopped going to the meetings, because they felt they weren't being engaged with and they couldn't engage."* (SS-16-CL-H-12022018)

A respiratory pilot project was also implemented in Barrow as part of earlier vanguard activity. The pilot referred patients presenting at Furness General Hospital to a respiratory nurse practitioner and then subsequent care was provided by a community team.[18] Patients were given a self-care plan, help with medicine management and, if suitable, were enrolled in a pulmonary rehabilitation programme. The pathway has since been implemented in Barrow Town ICC and rolled out to Alfred Barrow ICC.[19] A further initiative involving virtual reality is also being implemented in Barrow.[20]

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[18] The Barrow ICC area has a high prevalence of respiratory conditions and a high number of patients presenting at A&E in Furness General Hospital with COPD or asthma related breathing difficulties were being admitted. The pilot aimed to facilitate early supported discharge for such patients by providing support in the community. 50 patients were enrolled in the pilot, and no patients enrolled were readmitted to hospital. In addition, 50% of the group were not known to the community team prior to the pilot; they were referred for pulmonary rehabilitation with the aim of reducing future demand on emergency and secondary care services.

[19] Better Care Together (undated). *Case Study: Respiratory Care in Barrow-in-Furness: PDSA Cycle.* http://www.bettercaretogether.co.uk/uploads/files/Respiratory%20Case%20Study%20-%20June%202017%20BCT%201.0.pdf

[20] A virtual reality exercise programme, PRinVR (https://fabnhsstuff.net/2018/04/11/pr-vr-virtual-reality-pulmonary-rehab-programme/) has been introduced by one Barrow GP in response to low numbers of physiotherapists, and the limited use of self-training programmes amongst respiratory patients. This work is being evaluated by the University of Salford.

3.3 A New Model of Respiratory Care: What's Changed?

3.3.1 Overview of Implementation

Section 1.3 provided an overview of the new respiratory care model. To date, only some of its components have been implemented: the multi-disciplinary teams and the appointment of a GP lead in each of the bundle 1 ICCs. These leads were invited to establish an ICC respiratory team as they deemed appropriate, but at the time of writing this report, only a small number of interviews with representatives from these teams have been completed. As such, the evaluation data collected to date does not show how each of the five bundle 1 ICCs have responded to the model's 'ask' to establish a team and develop new ICC respiratory clinics. Although the documentation provided by the MBRN and vanguard indicate that a lead GP has been appointed in each ICC[21], not all have been interviewed. In addition, several staff named as a member of the wider respiratory team in these documents declined an invitation to participate, reporting a lack of involvement in, or knowledge of, the new model of care.

It is possible that the partial implementation of the model has meant that some roles have not yet been engaged in its delivery (and there is no written timeline for delivery to indicate when they would be expected to be engaged). Therefore, at this stage it is not known if the levels of participation in the evaluation are indicative of a lack of engagement with the process of change, limited progress in the ICC's implementation of the model or simply an unwillingness to take part in the evaluation.

It is important to acknowledge that the emerging findings, at this point in the evaluation, do not necessarily reflect how the model has been implemented across all bundle 1 ICCs. Instead, the data presented in this report presents insight into how the new respiratory care model is being implemented in a narrow range of contexts. The remainder of the evaluation will aim to explore its implementation across the wider Morecambe Bay Footprint.

3.3.2 The Roll Out of the Bundle 1 Activity Package

The MBRN's model of care was presented to the BCT Delivery Group in June 2017 and the roll out of the first phase (bundle 1) was approved by the Delivery Group in August 2017. The vanguard investment in this phase of the roll out was £311K.[22] In October/November 2017, two MDTs became operational and GP leads were appointed in each of the bundle 1 ICCs. As described in Section 1.3, the new model ultimately aims to establish community clinics, which include MDTs, in each of the three localities in Morecambe Bay. Table 2 below summarises this locality structure

[21] BCT (2017). *New Model of Care: Morecambe Bay Respiratory Network (MBRN) – Vanguard Information and Contact Details.*

[22] MBRN (2018). *Bay Health & Care Partners: Respiratory Case for Change Proposal*

Table 2: Locality Structure[23]

Locality	ICCs Covered	Acute Trust
North Lancashire	Queen Square* Carnforth* Lancaster* Bay*	Royal Lancaster Infirmary
Kendal	Kendal East Grange & Lakes	Royal Lancaster Infirmary Westmorland General Hospital Furness General Hospital
Barrow	Alfred Barrow Barrow Town* Millom Ulverston, Dalton & Askam	Furness General Hospital

* Bundle 1 ICC

Reflecting this implementation timeline, the bundle 1 MDTs and GP leads had only been in place for 2-3 months when the evaluation fieldwork commenced. In addition, the interviews that have been conducted with the ICC respiratory teams indicate that although they have engaged with the MDTs from their inception, their wider ICC response was not implemented until later. For example, new respiratory clinics were established in one ICC in January 2018. Further details on each of these components are presented in turn below.

3.3.3 Multi-Disciplinary Teams

The MBRN model of respiratory care aims to establish new community clinics in each of the three localities in Morecambe Bay. These clinics will bring secondary care respiratory specialists out of the hospital to work with primary and community care staff. Patients would be reviewed at these clinics and it is expected that this will lead to ICC staff being upskilled.[24] It was originally envisaged that MDTs would run as part of these clinics but to date, MDTs are the only element of this component that have been implemented. The two MDTs that are established (in the Barrow and North Lancashire localities) run monthly and GP leads in each of the bundle 1 ICCs are able to present cases for discussion in the MDT meetings. As stated in the Case for Change document, MDTs "*will mean many more patients can be discussed that could be traditionally seen in out-patient clinics.*"[25]

The expectation is then, that this component of the model will lead to a reduction in new outpatient appointments. Based on discussions with the BCT Research and Evaluation Group and members of the MBRN, it is understood that one of the KPIs will relate to reductions in outpatient appointments.

The interview data suggests that attendance at each MDT differs according to which cases are being reviewed, but 'core' MDT members include: UHMB respiratory consultants, specialist

[23] Adapted from MBRN (Undated). *ICC Respiratory Team Lead Clinician Introductory Pack*

[24] MBRN (2017). *Morecambe Bay ACS. Case for Change in Respiratory Services, p.6*

[25] MBRN (2017). *Morecambe Bay ACS. Case for Change in Respiratory Services,* p.7

respiratory nurse, pulmonary rehabilitation team members and GP leads. Despite their short period of operation, where interviewees were aware of the MDTs, perceptions and experiences of them were overwhelmingly positive. For example, one interviewee described the MDTs as:

> *"… probably the most vital, sensible, patient-serving and clinically uplifting that has actually happened in my experience of all of the developments in the last however many years. It's just so sensible. It's just a way of bringing the right people together to provide care for the patients."* (LB-17-CL-H-13022018)

3.3.4 GP Leads

GP leads have been appointed in each of the bundle 1 ICCs. As one interviewee described, they are responsible for the improvement of respiratory care in their ICC:

> *"In the ICCs that are contributing, we have identified a lead GP who will take responsibility for improving respiratory care. Practically, that means identifying difficult patients, frequent flyers, frequent exacerbators, patients that have been going to hospital who are perhaps using a lot of medication, difficult diagnoses. All of their colleagues will know that if they've got a challenging case, instead of reaching for that referral, first of all they might discuss it with their GP lead*." (LB-18-CL-H-25012018)

To support GPs in this role, they have been given access to a secondary care link team, the MDT, CT imaging and are able to request other pulmonary function tests. In addition, a Lead Clinician Pack has been developed that includes pathways for diagnosis, exacerbations and the management of specific diseases. A full day's training with a respiratory consultation was also offered to GP leads.

3.3.5 Wider ICC Respiratory Team

As stated within the ICC Lead Clinician Pack[26], it is expected that the lead GP in each ICC will establish a wider respiratory team. Members of this team are to include those in the ICC who are involved in respiratory care (both community and practice based staff) such as Practice Nurses, District Nurses and Community Staff Nurses.

Some bundle 1 ICCs have established additional respiratory clinics, which are described in an update report to the BCT Delivery Group as providing "*rapid access for diagnosing respiratory disease and dedicated extended clinic appointments for patients with unstable respiratory disease.*" (p4[27]). Little of the interview data collected to date relates to these clinics, but the MBRN update report states that such clinics have now been established in the majority of Lancaster, Morecambe and Carnforth practices. However, it goes onto describe how the relatively small size of Barrow practices have limited their success in implementing clinics (p4). The MBRN expects

[26] MBRN (Undated). *ICC Respiratory Team Lead Clinician Introductory Pack*

[27] MBRN (2018). *Bay Health and Care Partners. Respiratory Case for Change Proposal.*

Barrow to work with the remaining practices in the locality to share resources through a Primary Care Network model.

3.3.6 Community Teams and Further Investment

The MBRN aims to develop the capacity of community teams so that patients can be treated at home rather than in hospital. It was reported by participants that, to date, no additional investment in these teams has been made. Perhaps reflecting this, the staff from these services that have been interviewed described their frustration at the lack of changes brought about in the community:

> "*I don't want this to sound negative but from a community respiratory service perspective, it hasn't changed yet. The only thing that has changed really is with the existing staff in the service. Whatever developments we've done with our existing funding because we've tried to think differently and to change… our understanding at the very beginning was that there would be a shift of funding resources and knowledge from secondary care to primary care so that we can deliver more community-based care. That just – certainly from a respiratory perspective – we have seen no increase in funding. It hasn't impacted. The only thing it has impacted on is our time.*" (SS-16-CL-H-15022018)

Indeed, participants made clear links between the available investment and the absence of additional capacity within community care services, and specialist nurses in particular. This absence was widely acknowledged by interviewees to limit the improvements that could be made to the management of respiratory care; particularly regarding non-elective attendances and bed days.

> "*The big way to save money is to get people out of the hospital quicker and prevent them going in. In order to do that for respiratory patients, the pathways that we've looked to design, you need some extra staff in the community to coordinate that. The patients needed a specialist nurse. Because* [the available investment did not allow an increase in community teams] *we weren't able to recruit that person, we couldn't do that whole part of the network, so we've only been able to do odd bits.*" (SS-11-CL-H-23012018)

Similarly, the MBRN's March update report to the Delivery Group stated that:

> "*All MBRN lead GPs have identified that a lack of sufficient community service capacity has significantly impacted on their ability to maintain patients with the highest clinical needs in the community. In particular, poor access to pulmonary rehabilitation (PR) services with waiting times of over 8 months in Barrow has resulted in many patients being admitted where they could have been adequately maintained in the community.*"[28]

The interview data collected so far suggests that this is a key challenge facing the MBRN's model of respiratory care. To achieve the outcomes required by commissioners, they must first

[28] MBRN (2018). *Bay Health and Care Partners. Respiratory Case for Change Proposal, pp.4-5*

demonstrate reductions in secondary care activity. But the MBRN expects that reductions will be limited to outpatient appointments, rather than non-elective attendances, in the absence of additional investment in community respiratory services.[29]

> *"…in order to release money, you've got to prove that something works. How do you do that, without having that resource?"* (SS-16-CL-H-12022018)

> *"What you won't see in the context of a winter flu crisis, is any effect on inpatients. Which is the Holy Grail. This is where I think we are going to come up against a big stumbling block, is that you are expected to deliver miracles before you've even done the process. That would be a longer-term aim, but that would be contingent on us getting funding, to make an effective community respiratory nursing backup. That's the key to trying to get numbers down in hospital…"* (LB-18-CL-H-25012018)

3.4 The Process of Change: Mechanisms Enabling and Disabling the Implementation of the New Respiratory Model of Care

The preceding section provided an overview of the model's implementation to date. The interview data, although still incomplete, provides an understanding of what mechanisms are enabling and disabling this process of change. These emerging themes fall into three main areas:

- model design and leadership (covered in themes 3.4.1, 3.4.2 and 3.4.3);
- improved ways of working and upskilling (3.4.4 and 3.4.5); and
- use, type and availability of resources (3.4.6, 3.4.7 and 3.4.8).

3.4.1 The Change Management Approach

One of the key themes to emerge from the evaluation data is the distinctive approach taken to the design of the model of care and change management. The available evidence indicates that the MBRN's model for respiratory care was developed by a small number of people who were passionate about improving the quality and efficiency of care. This group consisted of a GP, a respiratory consultant and a commissioner and is described hereafter as the MBRN leadership group (although it was not formally established as this, it being used to distinguish those who were involved in the new model from the outset from other interviewees).

The MBRN's development began in the wake of the earlier attempt to redesign respiratory care in Morecambe Bay (see above, Section 3.2.4). Although this earlier model was not implemented, it appears to have provided a catalyst for the development of an alternative approach to

[29] Discussions at the April 2018 BCT Research and Evaluation Group meeting indicated that the MBRN was intending to present evidence on the progress of the bundle 1 roll out and its impacts to the BCT Delivery Group in May 2018 (and the timing of this report was intended to coincide with this meeting date), at which a decision on the future investment in the model's roll out was expected. However, the BCT Delivery Group has now been disbanded and an alternative route to securing further investment was being identified at the time of writing this report.

respiratory care. For many of those interviewed, the process of change was perceived as an iterative one that operated largely autonomously from the formal meetings and project management processes they had encountered previously, describing it instead as something more like "*a guerrilla insurgency..*" (SS-11-CL-H-23012018)

Instead, the interview data collected to date suggests that the new model emerged from a process of dialogue and engagement. For example:

> "*... if you were Mr Hunt from the Department of Health, let's say, I would want to see all the documentation and reports and outcomes from your respiratory network development. But I would really struggle to find anything because every week it's evolved. All these things have evolved as a result of a conversation with* [name*] *here, a conversation with* [name*] *here. The way I think it's worked so quickly is, you modify it, it's an integrative process bumping along.*" (SS-11-CL-H-23012018)

> "*I think it's the personal angle here, that has definitely been a catalyst to it working. Finding people who are enthusiastic, who are willing to start something off and not get tied up in the planning. The paperwork can come almost to the point where nothing ever happens. If you can start a project and show that you are actually doing something more efficiently, then hopefully that means that people will actually start to support you financially.*" (LB-18-CL-H-25012018)

Participants from the MBRN leadership group described how their working styles 'clicked' and led them to go onto find other "*like-minded people... who share that drive too*". Key to this approach is an understanding of the expertise held by different specialities and roles across secondary, primary and community care services, and that better care is dependent on joining that expertise up. Interviews with other staff involved in the bundle 1 roll out support this assertion; they described how they had been engaged in the redesign process and their expertise valued:

> "*From a clinical perspective, they appear to be on the same page and understand each other's roles and responsibilities, understand where each person's skillset starts and finishes, where the consultant is required and what the GP can actually do and what the specialist nurses can actually be responsible for and what skills they've got.*" (SS-18-PR-H-05022018)

> "*The main thing that [*name] *brought to it was engagement. He reached into the community and said 'tell me what's going on. Tell me what's needed.' And was genuinely interested and listening.*" (SS-16-CL-H-12022018)

> "*Right from the start, he's kept me up to date. He's sent documents that he has developed. We have always known what his vision entailed and how we could fit in with that.*" (SS-17-CL-H-6042018)

> *"It made you feel valuable, that we mattered as a [*name] service, that they valued our input. That gives you a warm, fuzzy feeling to start with. It makes you feel valued."* (LB-17-CL-H-13022018)

This approach appears to have overcome the reservations amongst some staff who were initially unwilling to engage in *"yet another"* attempt at changing respiratory care:

> *"I think when this was first put out there, it was like 'what?' or 'oh, we've done this before. Here we go again.' But I think through* [*name] *determination and enthusiasm, he's easily got us on board."* (SS-17-CL-H-06042018)

> *"Because of our experience with BCT, having given up so much of our delivery time, when we were initially approached, we said no, we can't do this because we spent two years trying to work with BCT, costing us delivery time, using up our small resource. We actually said, 'no sorry, we can't be part of this. We simply have to get on top of our waiting list, we have to do this that and the other.' They came back to us and said, 'if it's on a Friday and we fund your time, can you do that?' So we decided that although we both love Fridays* [a day off], *it was really important."* (LB-17-CL-H-13022018)

The available evidence indicates that the MBRN has succeeded in engaging respiratory staff from the hospital, the ICCs and community services in the bundle 1 roll out. It will of course be necessary to explore the inclusiveness of this engagement across all ICCs and community services in the next phase of the evaluation (it's not yet know if everyone that could have engaged has done so). Nevertheless, the approach adopted by the MBRN lead group appears vital; they were able to work with staff from across the bundle 1 area and engage them in the service redesign despite a widespread sense of disillusionment with the vanguard.

Many of the features of MBRN approach to change resonate with the concept of a collective leadership culture, which the King's Fund has argued is needed in the NHS to achieve high-quality care. Collective leadership involves *"the distribution and allocation of leadership power to wherever expertise, capability and motivation sits within organisations"* (p7[30]). Such a culture is dependent upon organisations coming together to delivery care, to achieve this, leaders must *"communicate an inspiring, forward-looking and ambitious vision focused on offering high-quality, compassionate care to the communities they service."* (p10).

3.4.2 Perceptions of Change

As previously described, many interviewees were frustrated by the lack of change brought about by earlier redesign initiatives, which involved much discussion and time invested but had returned little in the way of perceived change. The change brought about by the MBRN then, although only a partial implementation of the overall model, was perceived as an unusual event:

[30] West, M., Eckert, R., Steward, K. and Pasmore, B. (2014). *Developing Collective Leadership for Health Care.* The Kings Fund. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/developing-collective-leadership-kingsfund-may14.pdf

> *"I would say it has actually gone beyond my expectations. Firstly, because it happened. That's a new one, so that's good. It actually happened. We weren't just having meetings about it. We had a chat about it, a discussion and then it happened really quickly."* (LB-17-CL-H-13022018)

> *"What's great for people like me to see is things happening, not talking, but happening. When you see change and people are doing, that makes such a difference. It makes a difference to staff, it makes a difference to patients."* (LB-17-CL-H-13022018)

Not all interviewees had been affected by the changes made to date, however. For some community service staff, for example, little was perceived to have changed and there was concern that this model of care would follow the pattern of previous initiatives:

> *"The only positive thing as I say is* [*name] *enthusiasm and hard work, which is fab. I just hope that the CCG listen. Otherwise that's another clinician that's just worked their socks off, tried really hard and been disappointed again, which seems to be the pattern."* (SS-16-CL-H-15022018)

As reported in HASCE's 12-month evaluation report, experiences of previous initiatives are an important determinant of staff willingness to engage with new programmes and initiatives. In the case of respiratory, the lack of change brought about by earlier redesign projects meant that staff were initially wary of participation in the MBRN. Its ability to introduce new components into the service has, at least amongst some staff, altered perceptions of the change process.

In the next phase of the evaluation, key areas of consideration will be:

- Where these changes should be most visible (by synthesising qualitative data with quantitative reporting); and
- How these existing perceptions, and the shift in approach to change management affect the roll out of the bundle 2 and 3 activities.

3.4.3 Buy-in

A key enabler for the MBRN was seen as clinician or managerial buy-in into the new model. Interviewees described the importance of buy-in from clinicians:

> "*Critical [*to success] *is clinician support, right across the board. If you don't have the clinicians with you, you can't implement any change. It doesn't matter which manager signed it off, if the clinicians don't want to do it, if they don't see the value in it, they're not going to do it. Clinical buy-in and support is absolutely fundamental."* (SS-17-PR-H-190222018)

> *"I think the GP buy-in has been a huge factor of success. They could all have said they didn't think it was going to work and they're not going to come, but all of them have been great. They've all come to all of the meetings. They've embraced it. They've actually been through*

their patients and found the complex patients that they want to discuss. And sometimes GPs in primary care can be very hesitant to try new things but these guys have all completely embraced it." (SS-01-02-PR-H-19042018)

For some clinicians, the contribution of time to the MBRN was dependent on the support of their managers. Where managers were supportive of the new model, clinicians were able to adapt their working day to accommodate the additional workload. In contrast, a few interviewees observed that there was a lack of managerial buy-in in some bundle 1 ICCs. Anecdotal evidence suggested that ICC respiratory team members in such areas were working on their day off to implement the new model.

3.4.4 Communication

One of the key changes taking place in the bundle 1 roll out was the introduction of new MDTs to discuss cases. The interview data suggests that the MDT discussions are removing the barriers to communication that previously existed between primary, secondary and some community care services. As reported in the 12-month evaluation report,[31] wider vanguard activities include the Advice and Guidance initiative, which enables ICC staff to access the expert knowledge of hospital staff. The MDTs appear to develop this question and answer service by facilitating in-depth discussion of cases.

> *"…It's massively breaking down barriers. When you sit in that MDT and everyone suddenly goes, "ah, you're the physio I've been writing to!" and suddenly its personal… you can't integrate unless you physically sit in the same room together, at least some of the time."* (SS-11-CL-H23012018)

> *"Also, you get to know people as well* [at the MDTs]. *One of the best things is that if you do have a problem, you can just pick up the phone and you know who you are talking to on the other end, and they know who you are."* (LB-10-CL-H-13022018)

Although MDTs have 'core' members, they appear to be open to anyone who has knowledge of the patients being discussed. For example:

> *"I've been to one, because I was asked to present a patient at the first one. It was excellent. It was really good. I think the context from our knowledge of that person, because we visited him at home, was really helpful for the doctors to see."* (SS-09-CL-H-19032018)

This openness to the different expertise of staff was for one, key to how MDTs had broken down the barriers to communication. Another suggested a larger part of their enthusiasm for the new model was precisely the factors which allowed this to happen:

[31] HASCE (2017), *Local Evaluation of Morecambe Bay PACS Vanguard: 12 Month Report,* p.66

"Conversation, commitment, teamwork, the resource to actually have that time to meet. The link between so many different strands of the puzzle if you like, and an openness to everybody listening. A real openness to listening." (LB-17-CL-H-13022018)

3.4.5 Upskilling Staff

The MDTs give clinicians access to the expertise of different specialities and roles and in doing so, are upskilling staff. Again, the apparent openness to learn from the respective knowledge and skills of other staff is important here:

"*Now I have a system where I can go in a very easy way to the clinical lead for that practice, and actually help upskill, discuss in a very non-threatening way, where we might need to put in more education, where we might need to work together for the patient. People are very receptive.*" (LB-17-CL-H-13022018)

Although interviewees described how staff from different specialities contributed to a shared learning process, it was clear that the attendance of a respiratory consultant in particular was key in advancing knowledge and skills. One interviewee described how patient cases were discussed in the MDTs:

"*… he actually brings up the x-rays on his computer and shows people… if you're talking about bronchiectasis or something and he said to me 'I would say this needs this treatment.' So people can actually look on the screen and see how he interprets it, and watch how he's explaining it. Which is a lot more effective because otherwise they wouldn't see what he's seeing.*" (SS-01-02-PR-H-19042018)

Interviewees described several different training activities that they had been a part of. In addition to the MDTs, written protocols and training days have been introduced to support the ICC respiratory teams. It was reported that GP Leads attended an away day and nurses were invited to attend a training day which was run by the GP Federation working alongside the MBRN.

The development of primary care staff is a key feature of the new respiratory model. It is expected that the increased knowledge and skills of practice staff will reduce the number of patients referred to outpatients:

"*If you give* [GPs] *access to investigation, a little more training and confidence and multi-disciplinary review every month, they can manage the vast majority of stuff out in primary care. You can only reduce demand if you've got a bit of upskilling of the primary care workforce, and also increasing their abilities.*" (SS-11-H-23012018)

"*Key to reducing outpatients, or new outpatients anyway is the upskilling of general practice. So, a lead GP in every practice and also Practice Nurses, Health Care Assistants, Pharmacists and anybody else they've got who can deal with their own internal referrals.*" (SS-17-PR-H-19022018)

Many interviewees thought that the increased knowledge and skills of practice staff was already affecting referral pathways:

> *"[The MDT has] kind of developed into this huge learning. Let's put it back into the GP surgeries, let's look at how patients – and saying, do we need to have them in acute? Can we write to them and say, 'you've been discharged from respiratory acute, but you're very welcome to come to our surgery because to be honest, you only need one inhaler and you shouldn't be having three CT scans a year.'"* (SS-01-02-PR-H-19042018)

3.4.6 Capacity for Change

As with other aspects of vanguard-funded activities, how capacity is created for change is key to the implementation of the MBRN. Interviewees described how they were developing and implementing the new model for respiratory care alongside the existing requirements of their role. Given the pressures on those in a clinical role (particularly in winter, when the fieldwork began), capacity to implement change was often limited:

> *"We are offering support and time where we can, but again, it's all on top of existing pressures."* (SS-16-CL-H-15022018)

> *"You do need some kind of backfill and cover to release clinical staff to do something different, without compromising their existing job roles, because they're not sloshing around with nothing to do in the acute hospital. It is a struggle… because they've been drafting proposals, they're in development, going to meetings. It is part of what you've got to squeeze into any given working day. Sometimes you need an extra bit of help or you might not go to a meeting that clashes and be two or three hours long."* (SS-18-PR-H-05022018)

Interviewees felt that the capacity of both staff and wider organisations to engage in the new model varied across the bundle 1 area. In one ICC for example, where all the surgeries in a single practice align with the ICC boundaries, the work required to set up the new respiratory clinics was carried out by a practice partner rather than by staff leading on respiratory care. In this instance, the practice partner was able to create the additional capacity required to implement the new way of working (through working more hours, for example). Two new clinics were set up in January 2018 and were run by the lead GP, two practice nurses and a pharmacist. The nurses' time in the clinics was backfilled by nurses from elsewhere in the practice who were willing to increase their hours. However, GP shortages meant that it was not possible to backfill the time of the GP attending the respiratory clinics in the same way. Managing this was described as a "*struggle*":

> *"We're all just trying to cope. I would suggest that other practices are really struggling because of that. Because we can't even fill our vacancies that we've got, let alone backfill a respiratory."* (LB-10-CL-H-13022018)

Another interviewee described how the response to the model's ask had varied across bundle 1 ICCs, with capacity identified as a disabling factor for some:

> *"The ones that have struggled are the ones that are under the cosh with their urgent care demand."* (SS-17-PR-H-19022018)

The capacity of general practice to implement change was also reported to be limited by the recent practice mergers. Although the mergers were now complete, personnel issues (e.g. ensuring the right number of staff are at each site) were reported to be ongoing. For one interviewee, general practice needed to find a way to break out of the urgent care cycle so that they could implement change:

> *"They need that little bit of breathing space to reorganise themselves to turn a little bit of their reactive workload into proactive workload… if you can't break out of your urgent care demand, you're not going to be able to put in place the solutions you need to reduce that demand. It's a catch 22."* (SS-17-PR-H-19022018)

The vanguard funding had, for a few interviewees, provided a mechanism that could break this cycle. The funding had been used to buy the time of staff and release them from some elements of their role or to work additional hours.

> *"Although we want to work and make things better, we haven't got that resource to do it. That's our problem really…. We do multi-disciplinary team on our day off and it's funded. That was the only premise we could do. We could not fit it in. We do that once a month and it is funded and that's great."* (LB-17-CL-H-13022018)

In the absence of funding to buy extra working hours or backfill the time spent out of their everyday role, change was dependent on the 'commitment and goodwill' of staff:

> *"None of my impact was* [funded by the vanguard]*. In fact, I did most of it in my own time. That's what we do here in general practice, we have to."* (LB-10-CL-H-13022018)

Capacity issues were not just limited to the model's clinical delivery. Interviewees also suggested that there was a need for more leadership and project management support.

> *"You then need dedicated project management resource, to support all the clinicians. Because they are clinical doers, they are not management doers. Another area we have struggled really is capacity of project management."* (SS-17-PR-H-19022018)

Although a formal, bay-wide leadership group was planned, it had not yet been established at the time of the fieldwork. One interviewee felt that absence of formal structures such as this had enabled the project to evolve quickly and easily but also recognised that a leadership group might have provided additional oversight:

> *"We should have really had a bit of an oversight group pulling the strings a little bit. I guess it would have been a little bit of a millstone around the neck of the project, but I think because it's all about engagement, I think if we'd had some kind of steering group, a really*

high level steering group, we could have maybe sorted out meetings regularly." (SS-11-CL-H-23012018)

It was recognised however that much of the initial development work was reliant on commitment and goodwill and that additional investment in leadership and project management was required to secure the future roll out of the MBRN model.

3.4.7 Implementation Timeline

Just as discussed in the 12-month evaluation report,[32] an emerging theme from the interview data has been a concern around the time allocated for the MBRN to demonstrate success. In addition to the problem of introducing effective change within the limits of a financial year, bundle 1 was reported to have been rolled out at speed. For example, one interviewee described how it felt "*incredibly new and… incredibly rushed."* (SS-11-CL-H-23012018)

The MBRN was required to demonstrate impact soon after its initial roll out to obtain approval for the continuation of bundle 1 and implementation of bundle 2 and 3. However, some interviewees described the challenges associated with demonstrating the model's potential outcomes in the short term.

> "*…all the things… put in the plan has been nationally evidenced of improving all outcomes in respiratory. But they won't show a cost saving by next year. In order to get some money – there's always talk of, well, we'll release a little bit of money if you can prove that reduced cost within twelve months. Well, it won't. It might in the next five years, but not this year."* (SS-16-CL-H-150222018)

> "*They're putting shorter-term aims on it. You almost get the feeling that they either don't understand it… or they don't want to fund a full service."* (SS-16-CL-H-15022018)

Reflecting the challenge of finding the additional capacity to introduce change in general practice, it appears that ICC respiratory teams would have benefited from additional lead in time:

> *"I would say that the way it was sprung on us was really pretty poor. The first we knew about this was September. There had been rumblings, I suppose, but the first education things were September, and then all of sudden it was supposed to be up and running within a month I think. There's no practice that hasn't struggled with that really."* (LB-10-CL-H-13022018)

Those interviewees acknowledging the limited timeline available to implement the model, felt that its achievements were all the greater because of this time pressure:

[32] HASCE (2017), *Local Evaluation of Morecambe Bay PACS Vanguard: 12 Month Report*, pp.82-3

> *"I think we've done really well in setting it up and we've run with it. We wanted to do it. I think it's a really good project. We were all enthusiastic about doing it, but I just feel it wasn't – we weren't given enough notice or enough help."* (SS-10-CL-H-13022018)

3.4.8 Vanguard Funding

Vanguard funding has enabled some staff to be released from their working day to implement and deliver the new respiratory care model. Reflecting this, some staff reported that they would not have been able to engage with it in the absence of this funding. However, the non-recurrent nature of the Vanguard funding acted as a disabler.[33] Interviewees were mindful that they were investing a considerable amount of time in the implementation of a care model that might not be financially supported in the longer term.

> *"That's another negative thing about it, that we know that we've got this hanging over us, that it's going to be reviewed in March. Is it going to carry on? Nobody knows. Is it worth all this effort if you're just going to pull it under the carpet? I would hope that the CCG have seen that we've actually done a pretty good job of getting it off the ground. But it's not long enough to see that it is working, really. January to March is only two months of data."* (LB-10-CL-H-13022018)

The uncertainty surrounding the future of the model led to one interviewee delaying its implementation:

> *"There's the lack of clarity about funding and next steps, which just makes it really hard to put the plans in place. We've held fire on connecting with other people because we've no idea what's happening. That just makes it really challenging, because we could start setting things up now if we knew we were starting in April but there's not much point because we've no idea."* (SS-18-PR-H-2102018)

3.5 Perceptions of Emerging Outcomes

The MBRN's model of care has only been partially implemented to date and this will have an effect on the emerging outcomes at this interim point of the evaluation. Alongside this, a triangulation of interview data and quantitative reporting has not yet been possible due to the limited access to quantitative data. It is expected that the local evaluators will be given access to a new respiratory dashboard in May 2018 and data will be collected from patients who have received care through the MBRN activities in the second half of the evaluation project. Analysis of the emerging outcomes is, therefore, based on the perceptions of those 17 staff members who have been interviewed to date.

[33] The structure of funding for new models of care was also discussed as a disabler for long-term change by many participants in the 12 month evaluation report. See, for example, HASCE (2017). *Local Evaluation of Morecambe Bay PACS Vanguard. 12 Month Report,* p.123 and p.176

Reflecting the early stage of the bundle 1 roll out activity, interviewees generally felt it was too soon for outcomes to be evidenced (the exceptions to this are highlighted in the following discussion). However, all were able to describe how they expected the new model to bring about changes in the management, delivery and experience of respiratory care. The types of changes expected can be summarised as falling into one of the following broad categories:

- Diagnosis;
- Care management;
- Reducing secondary care activity (reducing outpatient appointments and reducing non-elective attendances;
- Productivity;
- Staff experience; and
- Patient experience.

3.5.1 Improved Diagnosis

Most interviewees expected the increased communication between clinicians and the upskilling of staff to improve the accuracy and quality of diagnosis. Despite the early stage of implementation, a few interviewees described how discussions at the MDTs had already led to a different diagnosis for some patients:

> "*There are people who have been diagnosed with COPD for twenty years and the multi-disciplinary team has said "actually, he's got asthma. It's no wonder he's having exacerbations and he's ending up in hospital, because he's on the wrong meds."* (SS-17-PR-H-19022018)

The diagnosis timeline was also perceived to have been shortened with some patients now being diagnosed without the need for an outpatient appointment:

> "*That time from referral to diagnosis, definite diagnosis, was probably in the order of four months. We've now shortened that down to around a month because that same work is being done in a practice. It's a quarter of the time that it was previously."* (SS-17-PR-H-19022018)

3.5.2 Improved Disease Management

Interviewees commonly described how an improved diagnostic approach could lead to more effective care management and again, a few were aware of changes that had already been made to patient's treatment. More generally, the increased communication between primary, community and secondary care services facilitated by the MDTs was described as creating opportunities for staff to collectively learn, plan and provide patient care:

> *"I can see the patient benefit. We're seeing it every time we are doing the multi-disciplinary team. It's such seamless care for the patients. You are able to literally arrange things there and then. There's not this kind of hiccoughing of trying to go through all the different systems."* (LB-17-CL-H-13022018)

Interviewees also described their expectations that upskilled ICC teams would lead to the more proactive management of respiratory conditions:

> *"If you upskill general practice generally, then you'll pick up the deteriorating patients earlier."* (SS-11-CL-H-23012018)

3.5.3 Reducing Secondary Care Activity

As respiratory patients are increasingly managed in the community, it is expected that the demand for secondary care will be reduced and that beds will eventually be closed. Despite the early stage of delivery, interviewees felt that outpatient referrals were already being reduced. Again, much of this reduction was perceived as being brought about by the MDTs:

> *"The MDTs are crucial, just what I've heard about people's learning and skills development from that shared discussion of different professional inputs. Just purely the fact that GPs are referring to the multi-disciplinary teams much earlier than they would have referred to a consultant."* (SS-18-PR-H-21022018)

> *"I think a lot of referrals will potentially be diverted or prevented from going into secondary care by discussing them at these multi-disciplinary teams and just generally sharing the knowledge and understanding of conditions."* (SS-10-11-PR-H-19032018)

One interviewee described what evidence had already been gathered on reductions in new outpatient referrals:

> *"In the first half of 2017, we were somewhere around a 20, 25 to 30% increase in GP new referrals for respiratory. Since we started the project, in the pilot areas that's turned to a 30% reduction, so we've almost got a 60% turnaround already."* (SS-17-PR-H-19022018)

Although the evaluation team do not yet have access to the new respiratory dashboard, data on the number of new GP referrals for bundle 1 and 2 ICCs has been provided. As shown in Table 3 below, the number of new referrals made by GPs in the bundle 1 ICCs each month between October 2017 and January 2018 (the MDTs began in October 2017) was consistently lower than over the same period in the previous 12 months (October 2016 to January 2017). For example, in October 2016, 62 GPs made a new referral compared to 39 new referrals in October 2017. Furthermore, bundle 2 ICCs experienced a consistently higher number of new GP referrals over the same time period. As shown in Chart 1, the percentage change clearly shows that bundle 1 experienced a relative decline in new GP referrals and bundle 2 a relative increase for the period October 2017 to January 2018 when compared to the previous 12 months period.

Table 3: Change in New GP Referrals between Oct-Jan 2016/17 & 2017/18 by ICC Bundle[34]

	Month	October		November		December		January	
	Year	2016	2017	2016	2017	2016	2017	2017	2018
ICC Bundle 1	No. Referrals	62	39	62	29	57	44	49	41
	% Change 16-17	-	-37.1%	-	-53.2%	-	-22.8%	-	-16.3%
ICC Bundle 2	No. Referrals	45	61	52	76	49	55	37	58
	% Change 16-17	-	35.6%	-	46.2%	-	12.2%	-	56.8%

Chart 1: Percentage Change in New GP Referrals between Oct-Jan 2016/17 & 2017/18 by ICC Bundle[35]

Although caution should be used when comparing the number of referrals between these two areas (it is not known how comparable the two ICC bundles are in terms of the number of patients with a respiratory disease for example), the available qualitative data would support the attribution of the reduction in new referrals in the bundle 1 area to the implementation of the new MBRN model of care.

Consistent with this, interviewees observed that the number of referrals made by practice staff to the lead GPs, rather than to outpatients, was increasing each month:

> *"one of the many things that has been interesting about the MDT that we've had each month is that GP leads are getting more referrals from their GP and nursing colleagues*

[34] Source: EMIS Referral Data (MBRN, 2018)

[35] Source: EMIS Referral Data (MBRN, 2018)

within their practice – much more in terms of numbers than choosing book referrals to secondary care." (SS-11-CL-H-23012018)

Similarly, a representative from one ICC respiratory team explained that practice staff were now referring complex cases to the newly formed ICC respiratory clinics.

It is anticipated that the inclusion of an MDT referral code in the new respiratory dashboard would show how many GPs are referring patients to the MDT, and therefore enable further interrogation of this data.

Although interviewees believed that outpatient appointments were already being reduced, additional investment in community respiratory services was generally thought to be needed before non-elective attendances and bed days would be affected.

> *"I think a priority would be more to beef up community respiratory nursing support, to start to enable admission avoidance and early discharge more effectively than we are now."* (LB-18-CL-H-25012018)

Focus groups conducted with patients in year 1 of the evaluation highlighted the importance of a single point of contact in managing the anxiety experienced by people with respiratory conditions.[36] Similarly, some interviewees involved in the MBRN described how anxiety was triggered by breathlessness and it was this anxiety that led to 999 calls. A direct line of communication to a specialist clinician was thought to be important in reducing this anxiety and self-management of respiratory conditions more generally.

Supporting this suggestion, one interviewee described how the respiratory pilot in Barrow (see Section 3.2.4) had identified that patients admitted to hospital would have welcomed access to a clinician in the community and would have requested support before they needed to be hospitalised. More generally, there was a perception that patients need to be 'caught earlier' so that the right treatment and support could be put in place:

> *"I think its catching people earlier so that they get the right diagnosis earlier, but also, its catching people… as early as possible in their illness, when their behaviour isn't set up. People are able to learn about their condition more, learn how to manage it better, so you've not got into a cycle of "I'm now feeling unwell, I'm now feeling anxious because I'm unwell, I'm going to A&E. Whereas if you've got the right diagnosis, the right drugs and people have helped you to understand your condition, earlier down the route into your illness, it kind of all just makes sense doesn't it, really?"* (SS-18-PR-H-21022018)

The new respiratory dashboard will enable the identification of any changes that have taken place in non-elective attendances and bed days since the model was implemented. It is also

[36] HASCE (2017), *Local Evaluation of Morecambe Bay PACS Vanguard: 12 Month Report*, p.158

expected that the dashboard will support the monitoring of these indicators if and when further components of the model are implemented.

3.5.4 Productivity

Given the interim nature of this report, it is too early to cite evidence of how the changes brought about the MBRN have impacted on the productivity of care, but interviewees were clear about how this could be achieved. In general, patient reviews at MDTs were perceived to be a more efficient approach to diagnosis and care management (when compared to the previous route to outpatient referrals).

Firstly, they were reducing the time of the diagnostic process:

> "*If we take the example of a patient who is breathless and we are not quite sure why, it isn't clearly a heart problem, we think it is a lung problem. The GP would traditionally, a year ago, have done some tests at practice, probably an x-ray and a basic breathing test, a spirometry test, and then would have referred in unless there was a very obvious diagnosis there. There would have been a wait of a few weeks to come to clinic, we would have seen them and decided to maybe do a CT scan, a full lung function test – again, weeks delay to get those tests done. Then they either come back to clinic for another appointment to discuss results, or we have to write to them. Again, that's all quite time consuming, chasing up results on computers. Once you add up thousands of them, it takes up a hell of a lot of time."* (LB-18-CL-H-25012018)

Secondly, more patients could be reviewed in a 90 minute MDT than in a three hour clinic offering "*masses more bang for the buck*" (LB-18-CL-H-25012018). Importantly, the collective expertise in the MDTs meant that its members had more information available and were able to use this to make clinical decisions.

> "*… because you've got everybody in one room, rather than having each of those individuals meet separately for several hours each week, they are all meeting together. They can get through more patients, given the collective brain power of those clinicians in a room together, that have got different levels of expertise, that can agree a care plan quickly, than if each individual was doing it singlehandedly on their own. They would be producing more effective care plans and producing them more quickly so they would be more productive."* (SS-18-PR-H0202018)

Although it was acknowledged that some patients with more complex conditions would still require a new outpatient appointment, it was thought that each case reviewed in the MDT generally equated to one less referral.

Thirdly, the upskilling of general practice staff was a key pathway through which productivity was perceived to be increasing, alongside other factors that were also expected to improve productivity such as a reduced need for scans and a reduction in prescribing.

Conversely, the implementation of the pathway means that the time spent by practice staff on respiratory care was reported to have increased; staff were now attending monthly MDTs and some were also involved in new ICC respiratory clinics. Although the benefits of this additional investment of time were acknowledged, it was not yet known how cost-effective the approach was. Despite this, one interviewee felt that it had:

> "*definitely improved it* [productivity]. *It might be costing a lot of clinical time, but I think the emphasis on it and improving everybody's knowledge and doing it to a higher level, involving secondary care so you can do it – yes, the productivity must be better.*" (LB-10-CL-H-13022018)

Assessing the economic impact of the new model will be a core part of the next phase of the evaluation; this will provide additional insight into the productivity of the new model. Wherever possible, data on the amount of time staff have allocated to the new way of work and how this compares with the previous approach has been collected in the interviews.

3.5.5 Improved Staff Experience

The MBRN has invested time and resources into upskilling staff and establishing channels of communication across disciplines and areas of working. This has led to staff feeling better supported and more confident in their roles:

> "*In a very short space of time, practices are now empowered and are confident to make their own decisions and assessments about patients that were previously sent into hospital.*" (SS-17-PR-H-19022018)

> "*I could go on forever about how much better it is, because it's better for staff. I think the nurses feel happier because they've got more support, more involvement… They needed to someone to go to; they didn't have that before and they have that now.*" (SS-11-CL-H-23012018)

More generally, being part of a network that was perceived to be improving respiratory care was described by one as providing increased job satisfaction:

> "*I think they are getting much more satisfaction out of it, because I think they can see that perhaps they're making a big difference in this Respiratory Pathway, that you might not have seen before, just seeing patients on an annual basis for their review. This is a bit more intense.*" (LB-10-CL-H-13022018)

For another, the MBRN had provided a new sense of optimism that things could change:

> "*I feel hopeful for the first time in a long time. I was optimistic, and now I feel hopeful and I actually have a sense of things getting done that I haven't had, for a long time.*" (LB-17-CL-H-13022018)

The new model also appears to be increasing the confidence of staff in the care system. For example, when a patient is now discharged, staff know that there is a lead respiratory clinician who has direct lines of communication to the specialist knowledge if needed.

> *"…you know you're discharging them back to someone who has got an immediate link into the MDT, who has an interest in respiratory and will be able to keep an eye on them more closely."* (LB-18-CL-H-25012018)

Similarly, for those treating patients in the community, access to the MDT meant that they could now request a review of a patient as and when there was a change in their condition. This eradicated many of the staff's concerns quickly and efficiently.

3.5.6 Patient Experience

The MBRN's primary goal is to integrate care, deliver a service that treats the whole patient through improved diagnosis and care management, reduce referrals, and, in some instances, manage end-of-life care. As described above, patients were expected to benefit from faster and more accurate diagnosis and improved disease management more generally. Other examples of how changes brought about by the new model could eventually lead to improved outcomes were also provided. The joined up approach was thought to be increasing patients' trust and confidence in the care system:

> *"…we are gaining their trust over time and we are actually reinforcing their confidence in the system because you are able to say 'look, there is a lot of work going on, we understand.'"* (LB-17-CL-H-13022018)

> *"I think patients are smart, they understand that GPs in practice can't know everything. They feel much more reassured on the secondary care but it's a very inefficient use of the system. Just like for the consultant, having that confidence to discharge to us, the patient needs to feel that confidence. I think if you're coming to the* [ICC name*] *respiratory clinic, that's better."* (SS-11-CL-H-23012018)

The more rapid clinical decision making facilitated by the MDT was also perceived to benefit patients:

> *"It's good because we can see people, and if we need to get that advice we can go to Multi-Disciplinary Team meetings. It's quite a quick turnaround, because it's within a month. We can see them and have an outcome quite quickly, whereas if you're waiting for an appointment at the hospital, you would be waiting a lot longer."* (SS-10-CL-H-26022018)

Patients who have been through the respiratory pathway will be interviewed in the second stage of the evaluation project.

3.6 Views on Wider Respiratory Care

As reported in Section 3.5, additional investment in community respiratory services was perceived as being necessary to reduce admissions and bed days. Interviewees also described other ways in which they thought respiratory care could be improved; for example, through patient education, pulmonary rehabilitation and self-management of care. Although some interviewees expected that increased investment in community services would bring about additional activity in these areas, others thought that there needed to be a more fundamental shift from a medical to a more holistic model of health:

> *"…medications are highly valued and… non-pharmacological therapies are not valued and actually the non-pharmacological ones are the ones that will probably make the biggest differences… Like pulmonary rehab, patient support groups, education. There's a huge problem with education and all the documentation of self-management is historically very undervalued and underfunded."* (SS-11-CL-H-23012018)

> *"when you're looking at people's lives, it's about the whole of their life, not just focusing down onto the respiratory aspect, because it's how that respiratory aspect impacts on how anxious they feel, how socialised they are, whether they go out or get isolated. It's that whole bigger picture."* (SS-16-CL-H-12022018)

In many senses, this resonates with views around the need for a shift in culture engendered in some of the previous BCT vanguard activities.[37] The MBRN appears to be addressing similar challenges, albeit through markedly different leadership and management approaches.

Interviewees reported how condition management and education had traditionally been delivered through pulmonary rehabilitation alongside a programme of exercise. However, alternative approaches to delivering both education and exercise were highlighted. Airways cafes, which provide peer support and education, have recently been piloted in the Carnforth ICC and some interviewees were eager to see the cafes being run elsewhere:

> *"If we can get these Airways Cafes up and running at least weekly or fortnightly, it will be somewhere that people can come to avoid having to go to a GP or getting to exacerbation point and getting to an outpatients appointment. If they can come on a weekly basis, either before they go in or once they've been in and come out again."* (SS-10-11-PR-H-19032018)

Another described how additional resources would be needed to overcome the logistical difficulties associated with running the cafes alongside their existing roles:

> *"Again, the resources that are needed are not massive but it has been a drain on our team's district nursing. And there's been a member from long term conditions and a volunteer, so it's taken three staff members to run it, even though it's a small group. Just logistically, getting ambulance transport. Most of them are on oxygen, so you need staff around to*

[37] See HASCE (2017), *Local Evaluation of Morecambe Bay PACS Vanguard: 12 Month Report*, pp.173-75

make sure the environment is safe… It's been a very good outcome and if we can get some more resources, we would like to continue it because of the quality of life for those patients has really gone up since that café." (SS-09-CL-H-19032018)

Limited resources were also reported to have affected the availability of smoking cessation services, which were highlighted by one interviewee as critical to the management of respiratory diseases:

"Three years ago, South Cumbria had a smoking cessation service. They weren't getting as many people through as a CCG had set targets for, so they decommissioned. In terms of long-term reduction in spend on respiratory, smoking cessation is fundament to every single part of the pathway, from preventing disease to preventing flare ups of the disease, to lengthening life in those with the disease, and we have no smoking cessation service. There is a little bit of provision by pharmacists, but patients just aren't accessing it, or they are not getting the counselling. It's not even thought about ." (SS-16-CL-H-15022018)

Other examples of education and exercise programmes included a maintenance class, which supports the continuation of exercise after pulmonary rehabilitation and was identified by one interviewee as a less costly approach. Another described how they had "*taken the education out of pulmonary rehab*" and were now delivering a rolling programme of talks:

"It's the information that people used to get when they did pulmonary rehab. They would do an hour of exercise and an hour of education at a time when they were completely knackered. They'd spent however many hours getting ready to come, then they'd done their exercise, then we'd given them relaxation and then we'd say 'learn something about your disease.' We didn't think that was a good idea really… It meant that the only people who could attend education were those that were doing pulmonary rehab and that's a small number compared to the population of people with respiratory disease." (SS-16-CL-H-12022018)

For patients who are reaching the end stage of respiratory disease, the local hospice provides a Fatigue, Anxiety and Breathlessness service which offers patients and carers help and support to manage fatigue, anxiety, nutrition and sleep.

Regardless of how this information was delivered, it was widely recognised as being critical to improved condition management:

"[Patients] need to understand their COPD because everybody is different. People need to understand, what is normal for their chest? What are the warning signs to look out for? What's safe? What's not safe? If we can give people confidence in that, in that education, that understanding, that will stand them in good stead. There are a lot of people out there who just get on with it, they're just amazing. They manage it, they adapt, they understand their chests very well." (SS-18-CL-H-08022018)

This interviewee went on to emphasise the importance of supporting patients to manage their condition at the point of diagnosis:

> *"When somebody has been diagnosed, they need to be accessing the kind of input that is helping people learn to recognise good and bad habits of breathing… If we leave it too late, when somebody is too poorly to actually engage in ways of changing their habits of how they breathe, then it's not really so effective."* (SS-18-CL-H-08022018)

The interviews conducted to date suggest that the community clinics will enable a greater shift towards a more holistic approach. For example, the following quotes illustrate how staff are considering the best way to incorporate such services within the MBRN:

> *"Could we have third sector services, smoking cessation, pulmonary rehab sign-up there? Instead of saying to something, this is a great idea, to stop smoking, here's a phone number. Is that really taking it seriously? If we actually had it so we could send them down the corridor to see this person, it would be much more effective."* (LB-18-CL-H-25012018)

> *"… we are going to need… Occupational Therapy and Mental Health, which is vastly under-resourced and vastly underdone and also is a massive part of respiratory care... And a dietician. Really, if you're going to provide that kind of clinic, the patients would say that's also where you put your drop-in café… In an ideal world we would have a centre, where we could do all that."* (LB-17-CL-H-130220)

The 12-month evaluation report showed that the involvement of organisations outside of the NHS, such as third sector organisations, in the vanguard activities had been difficult to maintain. A range factors appeared to affect their involvement, including resources, communication and access to decision-making. As the MBRN continues to roll out, this evaluation will explore if and how wider condition management initiatives are incorporated into the bundle 2 and 3 activities.

4 Interim Recommendations and Next Steps

This section provides a summary of the key findings, recommendations based on these interim themes, and next steps for the evaluation project.

4.1 Overview of Emerging Findings

This interim report has presented the emerging themes from the qualitative data collected to date for the vanguard evaluation. As with any interim report, these themes must be viewed as iterative and subject to change and development as more data is collected and analysed. In addition, the synthesis of this data with quantitative reporting measures and economic analysis is yet to take place.

- The available evidence indicates that the MBRN has succeeded in engaging staff in the bundle 1 activity areas. This has enabled the implementation of two components of the respiratory care model, namely new MDT discussions of patients in the Barrow and North Lancashire localities, and the appointment of GP leads and their wider ICC respiratory teams.
    - However, interviews have not yet taken place with staff from each of the bundle 1 ICCs and reflecting this, it is not yet known if and how engagement and implementation varies across these areas. The conclusions presented here therefore refer to a narrow range of contexts, which will be widened as the model is rolled out to more ICCs.
    - Where there is evidence of engagement, it is clear that staff strongly support the new way of working. The NHS is a bureaucratic organisation that has traditionally operated within discrete structures or silos.[38] The MDTs are perceived to be breaking down the barriers created by this way of working and are enabling communication between specialities and primary, community and secondary care.
    - In turn, this communication is facilitating the learning and upskilling of ICC and community service staff, and secondary care staff appear to be benefiting from the more intimate patient knowledge held by primary and community care staff.

- Although interviewees acknowledged that it was too early for much of the expected outcomes to be evidenced, it was widely felt that the new way of working would lead to improved patient outcomes.
    - The MDTs were thought to be improving the accuracy, speed and efficiency of diagnosis, which meant that the right treatment could be put in place and importantly, that this happened without a long wait for an outpatient appointment or diagnostic tests. Some interviewees referred to cases where

[38] Collins, B. (2018). *Adoption and Spread of Innovation in the NHS.* https://www.kingsfund.org.uk/publications/innovation-nhs

there had been a change in diagnosis or altered treatment plans following a review at a MDT meeting.
    - It has also been suggested that the new model has had some unintended consequences for patients; the more joined up approach is thought to be increasing patients' trust and confidence in the respiratory care system.
    - Only a small number of patients had interacted with the new respiratory care model at the time of the fieldwork and therefore none have been interviewed to date. Interviews with patients will therefore form a core part of the phase 2 evaluation fieldwork and emerging themes such as this will be explored in this data collection activity.

- The MDTs and ICC respiratory teams are expected to reduce new outpatient referrals and the expansion of community care services to reduce non-elective attendances and bed days.
    - Interviewees believed that the number of outpatient appointments were already being reduced; by establishing the MDTs and appointing a GP lead in each bundle 1 ICC, the respiratory referral pathway was reported to have been successfully altered. The new GP referral data supports this assertion.

- Staff were also thought to be benefiting from the new model.
    - The newly appointed GP leads in each of the bundle 1 ICCs have attended training sessions and been given access to additional diagnostic testing, pathways, the MDT and specialist secondary care link team.
    - Reflecting their openness to the expertise held by different staff, practice nurses, physiotherapists and other staff are regularly attending MDTs and are therefore also being upskilled.
    - Access to multi-disciplinary expertise is enabling ICC, community service and secondary care staff to resolve concerns about a patient's diagnosis and treatment quickly and easily. The increased knowledge, skills and access to expertise is creating better supported and more confident staff, which in turn appears to be improving job satisfaction.
    - This still involves a comparatively small number of staff. As such, the scaling up of the model is likely to present more variations in the benefits felt by staff. This will be examined in the next phase of the evaluation.

- However, community care services have not received the investment needed to affect non-elective attendances and bed days.
    - Interviewees expressed the need for specialist respiratory nurses in the community and improved access to pulmonary rehabilitation.
    - Interviewees also described other initiatives or developments that they thought would improve respiratory care; these included a shift towards a holistic model of health and reflecting this, increased patient support to enable them to better manage their condition.

        - The lack of investment in community respiratory services to date was a source of frustration for many, particularly given the need to demonstrate a reduction in secondary care activity to commissioners before the funding required to invest in community care services would be released.
        - Similar to previous vanguard-funded projects, a tension exists between the processes for bringing about long-term, and the need to provide short-term achievements to secure investment. This revisits many of the issues raised in the 12-month evaluation report concerning decision-making and evidence-base for new models of care.

- The interview data collected to date indicates that the specific qualities of those leading the MBRN are critical to the achievements of the new care model.
    - A willingness to engage and learn from staff across different disciplines in Morecambe Bay appears to be a particularly strong enabler in securing the buy-in from staff to implement the model (at least, in those ICCs included in the evaluation fieldwork this far).
    - It is clear that, for some, vanguard funding has been important in securing this buy-in. Anecdotal evidence suggests however that vanguard funding alone is insufficient to generate such buy-in; interviewees were aware that the response of some ICCs had been limited by a lack of capacity or managerial support.
    - To date, the interviews have been with those members of staff who have engaged and it is hoped that a wider range of perspectives will be captured in the next phase of the evaluation.

4.2 The MBRN Respiratory Model: Considerations for Future Delivery

The available interview data has highlighted a number of areas that are perceived to work well and some that work less well. The timing of this report allows these learning points to be considered by the MBRN and wider BCT partners as part of the wider roll out of the model. In presenting these points for consideration, we are mindful that the MBRN are already aware of and acting upon some of the actions raised here.

- A particular success of the MBRN approach to change has been the openness and willingness to engage with staff from across primary, secondary and community care services. As a result, staff felt valued and any unwillingness to participate in the process of change was overcome. It is important therefore that this approach to the service redesign is maintained as the implementation is scaled up. A particular challenge here will be whether or not the particular qualities of those individuals leading the MBRN can be replicated amongst those engaging in its wider roll out.
    - To date, the model's success has depended on the goodwill and commitment of key staff members, which although challenging, has been sufficient to facilitate the partial roll out that has been achieved to date. However, the roll out of further bundles will require far greater capacity in these areas.

- The available evidence suggests that the sustainability of a wider model will depend on increased project management and leadership capacity.
- The management of this wider implementation, or scaling up of the model, will form a key focus of the next evaluation phase. At this interim stage, it appears that the approach to managing change in respiratory care resonates with a collective leadership culture. A collective leadership culture has been defined by West and his colleagues as:

  "*the distribution and allocation of leadership power to wherever expertise, capability and motivation sit within organisations… At a system level, collective leadership cultures for high quality, compassionate care reach beyond the boundaries of specific organisation. They provide the basis for the creation of cultures across the whole system, forging an interdependent network of organisations that work together to deliver high-quality care."*[39]

- Interviewees widely acknowledged that the lack of investment in community respiratory services meant that the model was only being partially implemented, which in turn constrained its potential to reduce secondary care activity (and non-elective attendances and bed days in particular). Moreover, the MBRN's ability to secure the investment needed was dependent on it achieving a reduction in secondary care activity. Although evidence-based commissioning decisions are critical to the achievement of high quality care, particularly given the financial pressures facing the local health economy, it is important that the performance of new initiatives are based on metrics that reflect a model's logic chain. Otherwise, evaluating its successes can become problematic.

- Related to this, the vanguard funding enabled components of the MBRN model to be tested. However, this is a non-recurrent fund and the uncertainty surrounding the future financial support for the MBRN has constrained some elements of its implementation. Therefore, succession planning should form part of the initial delivery strategy for non-recurrent funding streams (e.g. identifying what structure will take over responsibility for future commissioning decisions), in order to avoid the disabling factors raised in the 12 month evaluation. This would ensure that effective initiatives can be commissioned and continue after a fund has ended. It is however acknowledged that the future commissioning of activities previously funded by the vanguard have been affected by wider changes in Morecambe Bay's senior leadership team.

- The timeline available for the roll out of the bundle 1 activities was criticised by some interviewees. For those responsible for its overall design, there was concern that the model's potential impact could not be demonstrated in the timeline allocated. In addition, ICC respiratory teams requested further lead in time to allow them to prepare for the model's implementation. It is recommended that Key Performance Indicators are

[39] West, M., Eckert, R., Steward, K. and Pasmore, B. (2014). *Developing collective leadership for health care.* The Kings Fund, p.7

'layered' against a prospective timeline, so that changes in practice can be recorded at different stages of development, in addition to the high-level metrics. This may allow for the likelihood of reductions in key metrics in an ICC to be predicted earlier, by comparing more localised KPIs with successful ICCs.

4.3 The Local Evaluation: A Summary of Progress and Recommended Next Steps

The data collection methods planned for this phase of the local evaluation included:

- a review of baseline and pathway monitoring data;
- analysis of minutes of key meetings;
- interviews with staff and patients; and
- observation of MDTs.

To date, a small number of minutes have been reviewed (and were found to provide little data of value to the evaluation) and 17 interviews with staff completed. The evaluation limitations arising from this progress and recommendations for future data collection activities are set out in this section.

4.3.1 Interviews with Staff

The data collected through staff interviews suggest that the evaluation has succeeded in capturing the views of those most engaged with the new respiratory care model but further interviews are required to understand the experiences of those that are less engaged. There has been little or no participation from some ICC respiratory teams to date. It is acknowledged that the fieldwork commenced during the busy winter period when the capacity of respiratory care staff to participate in evaluations is most limited. This may explain the pattern of participation observed, but it is not known if a lack of involvement in the model or progress in its implementation is also a factor.

Although the evaluation activities are still in their early stages, clear and consistent themes are already emerging suggesting that there are common and shared experiences of the model. The second phase of evaluation fieldwork will aim to determine similarities and differences in experiences of the model's implementation across a wider cross-section of bundle 1 ICC respiratory teams and those involved in bundle 2 and 3 activity packages. The support of the BCT vanguard and its partners in raising awareness of the evaluation activities and their purpose is likely to contribute to increased participation rates.

Additional interview data will therefore help to determine:

- In which contexts do ICC respiratory staff engage (or not) with the new model of care? For example, does practice size, disease prevalence or other initiatives affect buy-in or capacity for change?;
- How different contexts shape the implementation of the model and its outcomes?;
- Membership of ICC respiratory teams and how this differs across Morecambe Bay; and

- The response of different ICC respiratory teams to the model's ask, including the variables affecting the sustainability of the model moving forward.

4.3.2 Interviews with Patients

To allow for sufficient numbers of patients to interact with the new model of care, this evaluation activity was delayed and is now scheduled to begin in May 2018. Patients who have attended an ICC respiratory clinic (and community clinics if they are established within the evaluation's timeline) or whose case has been reviewed at a MDT will be invited to take part in an interview. The invitation to participate will be disseminated by a member of staff who is in contact with the patient on behalf of the evaluation team. It is anticipated that most interviews will be conducted face-to-face to allow an in-depth exploration of:

- experiences of respiratory care before and after the implementation of the model;
- perceptions of the effectiveness of respiratory care before and after the implementation of the model;
- perceptions of changes in respiratory care and how patients have been affected by them;
- emerging themes, such as trust in the care system and confidence in clinicians to deliver the care needed (and how this has been affected by any perceived changes); and
- perceptions of what has worked well, less well and what could be improved.

The patient interview data will then be triangulated with that collected from staff and the quantitative data to assess the changes brought about by the new respiratory model and their impacts. The number of patients who have interacted with the model is not yet known and reflecting this, it is difficult to predict how many interviews will be completed. It is expected that the total number of patient interviews will however exceed 20.

4.3.3 Observation of MDTs

Observation of the MDTs are expected to commence in May 2018 and will provide more in-depth understanding of how the individual members of staff involved in the MDTs are working together to achieve these outcomes. Importantly, as the model is rolled out more widely, there will be an opportunity to explore if and how the success of the bundle 1 MDTs are replicated in the Kendal locality, and what the consistent features of success are.

4.3.4 Review of Baseline and Pathway Monitoring Data

Triangulating the qualitative data collected by the local evaluation with the quantitative data collated by the I^3 team at UHMB is a core part of the evaluation. A new respiratory dashboard is currently being developed by this team in partnership with the MBRN leaders. It is understood that this dashboard will provide aggregated data on respiratory patients' journey from diagnosis to end of life care by both ICC and practice. In doing so, it is expected to be a valuable resource both to the evaluation and those involved in respiratory care throughout Morecambe Bay. At the time of writing however, the dashboard was not available to the local evaluation team and it has not been possible to triangulate the qualitative data as planned.

In particular, it is hoped that the dashboard will provide the following data:

- The number of patients who have 'interacted' in the new respiratory model (although we understand that this is dependent on the creation of a new code for MDT referrals and ICC respiratory clinics, which is not yet in place);
- The services accessed by patients following an MDT review or attendance at a community or ICC clinic (for example, pulmonary rehabilitation, occupational therapy, smoking cessation, oxygen at home, long term care team);
- The number of patients referred to an outpatients clinic by ICC and practice (and how this has changed over time);
- The number of patients attending A&E by ICC and practice (and how this has changed over time); and
- The number of bed days by ICC and practice (and how this has changed over time).

It is anticipated that the presentation of data by ICC and practice will enable an assessment of the counterfactual. That is, the model has been implemented in five ICCs to date and a comparison of bundle 1 outcome data with the other ICCs will provide insight into what might have happened had the new model not been implemented. The similarities and differences between the ICCs (for example, practice populations, disease prevalence, smoking behaviour) will of course need to be established to identify the different contexts and baseline positions in which respiratory care is delivered in each ICC. This will inform an assessment of the extent to which observed changes can be attributed to the new model.

4.3.5 Next Steps

Based on experiences of the first phase of the evaluation, it is recommended that the second phase addresses the following objectives:

- Establish how the new respiratory care model has been implemented in a wider range of contexts through further interviews with staff involved in bundle 1, 2 and 3 roll outs;
- Explore how the implementation of the new model is scaled up and if a collective leadership culture is replicated in this wider roll out through further staff interviews;
- Explore what features of the MDTs are critical to breaking down communication barriers and upskilling staff through observations of MDTs in each locality;
- Explore patients' perceptions of changes in respiratory care and how they have been affected by these changes through in-depth interviews with those patients that have interacted with the new model;
- Triangulate the qualitative data with the quantitative data presented in the new respiratory dashboard;
- Use the data presented in the new dashboard to assess emerging respiratory outcomes against the model's KPIs; and
- Assess the economic impact of the new respiratory model (the scope of this assessment will be determined by the availability of input data; the evaluation team will continue to explore how time spent on respiratory care has been affected by the new model in the staff interviews).

By addressing each of these objectives, the evaluation's overarching aim will be achieved: to determine what context, mechanism and outcome configurations explain what works for who

and in what circumstances. This is of course dependent on the implementation of the bundle 2 and 3 activities in the evaluation's lifetime (a final report is scheduled for October 2018). In the absence of this wider implementation, the local evaluator and BCT partners will discuss and agree how best to maximise learning opportunities and evidence of change within the remainder of the evaluation.

Appendix One: Semi-Structured Interview Schedule

A. About you

My first few questions are about your job role and your involvement in the respiratory model.

1. Confirm job title and role
2. How long have you been in this role?
3. What do you think are the key issues for the provision of respiratory care in Morecambe Bay?
4. What is your role in the new respiratory model?
5. [If appropriate] At what stage did you get involved with its development?

B. About the model

I'd now like to discuss the respiratory model in more detail.

[For those leading the MBRN/ outside of the ICCs]

6. Why was the new model developed?
7. What would have happened to respiratory care in the absence of vanguard funding?
8. What development work was required to implement the model? [If needed: when did the development of the model begin?] Have any roles been redesigned or upskilled?
9. What training and support, if any, have you provided to the ICCs as part of the model's development?
10. What, if any, communication processes or systems have been developed to support the delivery of the new model? How effective do you think they've been?
11. How do the ICC Respiratory Teams work with the Respiratory Leadership Group?
12. In what ways, if any, is the model using new technologies?
13. At what stage are the plans for Community Respiratory Clinics in the ICCs?
14. How will they fit into the model?

[For ICC staff]

15. Is the new respiratory model fully operational in this ICC? As appropriate: when did this happen/ when do you expect this to happen?
16. Who is involved in the ICC Respiratory Team? Who leads it? Did you need to rearrange the practice team to set it up or backfill any posts? Is anyone from outside of the NHS involved in the team? If yes, what is their role?
17. [FOR ICC Leads] Are all patients with a respiratory illness in the ICC population included in the model? If not, who is included and why? When do these patients move onto the new care model – at the time of an exacerbation or routine appointment?
18. What would have happened to respiratory care if the new model hadn't been introduced?
19. How are care plans developed as part of the new model? Is this something you've been involved in to date? [establish how the patient is involved in the process] Do you know how many care plans have been developed as part of the new model?
20. In what ways do you expect care plans to affect self-management?
21. What development work was required to implement the model? [If needed: when did the development of the model begin?] Has your role been redesigned or upskilled in any way? What about other members of the team?
22. What training and support, if any, have you received as part of the model's development?

[FOR ALL STAFF]

23. What does the respiratory model do that's new?
    How was respiratory care provided before it was introduced?
24. Which features of the model do you think are key to reducing:
    - outpatient attendances?
    - non-elective appointments?

C. Experiences of model delivery

My next few questions are about your experiences of delivering the model.

25. Has the respiratory model been implemented and delivered in the way that was planned? If changes were made to the plans, what were they and why were they made?
26. Is the implementation of the model where you expected it to be at this stage? If not, why not?
27. The first stage of the evaluation found that staff responded to change in different ways and their response was affected by a wide range of factors. How have the ICCs responded to the new respiratory model? Why do you think that is?
28. In what ways, if any, has your experience of delivering care been affected by the new respiratory model?
29. What challenges have you faced in implementing the new model?
30. Did anything particularly help or support its implementation and delivery?
31. Is there anything else that could be done to improve the model? What resources would be needed to achieve this?
32. Overall, what factors are critical to the success of the new respiratory model? Do these factors apply to all the ICCs/ do you think these factors would be as critical in other ICCs?

[For those leading the MBRN/ outside of the ICCs]

33. Will you make any changes to the way in which the model is rolled out across the bundle 2 ICCs?

D. Outputs and Outcomes

[For those leading the MBRN/ outside of the ICCs]

34. Do you know how many patients have received treatment via the new respiratory model to date?
35. Have you had any feedback on patients' reactions to the new model?
36. Is there any evidence that the respiratory model has brought about any changes to date? [Establish how change is being measured] Have there been any unexpected changes or consequences?
37. How is the model performing against its KPIs? [Establish how KPIs are being evidenced if needed]
38. Once the model is fully operational, what do you expect its key achievements to be?
39. Overall, on a scale of 0 to 10, how effective do you think the new respiratory model has been in meeting the needs of those with a respiratory illness in [name of area]? Where 0 is not at all and 10 very. What would need to change to achieve a score of 10?

[FOR ICC STAFF]

40. How many patients have received treatment via the new respiratory pathway in this ICC to date?
41. How have patients responded to the new pathway? Have reactions been positive or negative?
42. Thinking about the issues facing respiratory care in this ICC, what do you hope the new pathway will change?
43. Is there any evidence that the pathway has brought about these changes to date? Is there any evidence of any other change? [establish how change is being measured] Are there any unexpected changes or consequences?
44. How is the pathway performing against its KPIs in this ICC? Who is capturing the data required to monitor the KPIs?
45. Overall, on a scale of 0 to 10, how effective do you think the new respiratory pathway has been in meeting the needs of those with a respiratory illness in [name of area]? Where 0 is not at all and 10 very. What would need to change to achieve a score of 10?
46. I'd also like to find out more about your views and experiences of the ICC more generally. Again using a scale of 0 to 10, to what extent has the ICC increased the integration of care in [area name]? Where 0 is not at all and 10 is very much. What would need to change to achieve a score of 10?
47. [If integration increased] What changes have been brought about by the increased integration of care? Have the ICCs had any unintended consequences?

E. Resource Change

My final few questions are about the resources required to implement the respiratory model.

48. Is your role funded by the vanguard funding? If yes, what proportion of your post is funded by the vanguard? When will the funding end? What will happen to your post then?
49. Have there been any changes to how you spend your time in an average working week since the new model was introduced? If yes, what has changed? [Wherever possible and appropriate, establish how many hours are spent each week working on the new model and how this compares to the time spent on respiratory care before the new model was introduced. In addition, establish breakdown of hours e.g. in consultations, meetings]
50. [Where time spent has increased] How has this increased time been resourced? What implications has it had for your role?
51. What other resources has the new model required?
52. Overall, how do you think the new model is affecting the productivity of respiratory care in Morecambe Bay? [How does the level of care activity compare to what was provided previously? Is care being provided at the same cost or a higher or lower cost?]

[For those leading the MBRN/ outside of the ICCs]

53. Has change in resource use been similar across the bundle 1 ICCs? Did any of the ICCs require more/less additional resources to implement the new model compared to the other ICCs?

F. Final Comments

54. That's the end of my questions, would you like to make any other comments about respiratory care or the Better Care Together programme more generally?